



October 31, 2017

RADM Michael D. Weahkee,
Acting Director
Indian Health Service 5600 Fishers Lane,
Rockville, MD 20857

Re: IHS Strategic Plan 2018 - 2022

Dear RADM Weahkee:

On behalf of the National Indian Health Board¹, we appreciate the Agency's request for comments on the draft Indian Health Service (IHS) Draft Strategic Plan for FY 2018-2022. We also appreciate that the agency will be creating a Tribal-Federal Workgroup to review input and comments on the Strategic Plan. As the only National inter-Tribal organization dedicated to health care for American Indians and Alaska Natives, we request a representative from NIHB be part of the workgroup. While we understand that the agency will continue to receive comments on the Strategic plan prior to finalization in February, 2018, we would like to underscore our disappointment at the lack of time to truly provide meaningful comments that are reflective of all 567 Tribes.² As a result, our comments are recommendations below are preliminary and we look forward to submitting additional detailed comments over the coming weeks.

Background

The United States has a unique legal and political relationship with American Indian and Alaska Native Tribal governments established through and confirmed by the United States Constitution, treaties, federal statutes, executive orders, and judicial decisions. Central to this relationship is the Federal Government's trust responsibility to protect the interests of Indian Tribes and communities, including the provision of healthcare to American Indians and Alaska Natives.

Further, Congress has passed numerous Indian-specific laws to provide for Indian health care, including establishing the Indian health care system and permanently enacting the Indian Health Care Improvement Act (IHCIA).³ In the IHCIA, for instance, Congress found that "Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical

¹ Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

² The Dear Tribal Leader Letter Announcing Tribal Consultation came out on September 15, 2017 and the deadline for comments is October 31, 2017, approximately only 31 working days.

³ 25 U.S.C. § 1601 et seq

and unique legal relationship with, and resulting responsibility to, the American Indian people.”⁴ The Indian Health Service (IHS) was created in 1955 to assist the U.S. to fulfill its obligation to provide health care to AI/ANs. Twenty years later, Congress enacted the Indian Self-Determination and Education Assistance Act of 1975 to enable Tribes and Tribal Organizations to directly operate health programs that would otherwise be operated by IHS, thereby empowering Tribes to design and operate health programs that are responsive to community needs. Title V of the Indian Health Care Improvement Act authorized federal funding for urban Indian organizations to provide health services to AI/ANs, many of whom had been relocated to urban areas by federal relocation programs. Together, this complex healthcare system is often referred to as the “I/T/U” (IHS/Tribal/Urban) or Indian health system. A year later, the Congress authorized IHS and Tribal health programs to bill Medicare and Medicaid, which expanded the resources available to them to carry out the federal trust responsibility.

The obligation to provide healthcare to AI/ANs does not extend only to the IHS. The federal trust responsibility is the responsibility of all government agencies, including others within the Department of Health and Human Services (HHS). Agencies like the Centers for Disease Control and Prevention (CDC); Substance Abuse and Mental Health Services Administration (SAMHSA); and Centers for Medicare and Medicaid Services (CMS) all must play a crucial role in ensuring that Indian Country receives both preventative and direct access to health services. As such, NIHB and Tribes request that the IHS Strategic Plan provide a preamble statement or appendix that details the federal trust responsibility to provide health to American Indians and Alaska Natives and the agency’s commitment to Tribal consultation. An example that includes suggested language can be found in the CMS Tribal Technical Advisory Group’s Strategic Plan (Attachment A).

Expand and Strengthen Goal 3, Objective 3: Modernize information technology and information systems to support data-driven decisions.

The Resource and Patient Management System (RPMS) serves as the IHS electronic health record (EHR), but it has struggled to support the modern health information technology needs and mandates. This system is outdated. While IHS has begun exploring whether to update or replace the system, this process will be a multi-year endeavor. Including modernization of the Health Information system for IHS as a clear objective and goal sends a clear message that this is a priority and is responsive to requests from Tribes. We recommend that Goal 3, Objective 3 be strengthened to reflect that the modernization will be a multi-year endeavor and require specific funding so as not to affect the delivery of critical health services to American Indians and Alaska Natives.

Specifically include objectives to promote the health care workforce for IHS

The Indian Health Service and Tribal health providers continue to struggle to find qualified medical professionals to work in facilities serving Indian Country. Current vacancy rates make it nearly impossible to run a quality health care program. With competition for primary care physicians and other practitioners is at an all-time high, the situation is unlikely to improve in the near future. What we do know, is that the IHS has been unable to meet the workforce needs with the current strategy and IHS must improve its ability to address workforce challenges if the care needs of AI/ANs are going to be met. The current IHS workforce development relies primarily on recruiting non-Indians through the loan repayment program,

⁴ Id. § 1601(1)

but those dollars are limited. A much more viable solution is to recruit native youth to enter into medical school. They are much more likely to return to and serve in native communities than non-native counterparts. Additionally, the care provided by Indian medical professionals result in more culturally informed care for all AI/ANs. However, the trend in AI/ANs going to medical school is alarming. In 1977, there were 124 AI/AN applicants to medical school, but by 2011 that number had shrunk to 101 – an almost 20% decrease. Perhaps more alarming is that only 20 out of 18,705 medical school graduates were AI/AN in 2015 – about 0.1%. An objective to recruit more AI/AN into the medical profession needs to be included in the Strategic Plan.

Conclusion

We thank you for this opportunity to provide our initial comments and recommendations on the IHS Draft Strategic Plan for FY 2018-2022. We look forward to continue working with you to improve the health of American Indians and Alaska Natives. Please contact NIHB’s Director of Federal Relations, Devin Delrow, at ddelrow@nihb.org if there are any additional questions or comments raised in this letter.

Sincerely,

A handwritten signature in cursive script that reads "Vinton Hawley".

Chairman, National Indian Health Board

Attachment:

American Indian and Alaska Native Strategic Plan 2013-2018, Centers for Medicare and Medicaid Services, Tribal Technical Advisory Group (February 20, 2017)



Centers for Medicare &
Medicaid Services'

Tribal Technical Advisory Group

American Indian and Alaska Native
Strategic Plan
2013 - 2018

Revised February 20, 2014

Includes New Addendum

The 2013-2018 CMS-TTAG AI/AN Strategic Plan covers the time period from Fiscal Year 2013 to Fiscal Year 2017, which begins on October 1, 2013 and ends on September 30, 2018. The CMS Budget Recommendations contained in the plan will be used to inform budget requests beginning Fiscal Year 2014.



Cover and Graphics by Maisie MacKinnon 2013



CMS Tribal Technical Advisory Group

W. Ron Allen, TTAG Vice-Chair
Chairman, Jamestown S'Klallam Tribe
Tribal Self Governance Advisory Committee
Representative

Frances G. Antone
Legislative Council Member, Tohono O'odham
Nation
Tucson Area Representative

Pearl Capoeman-Baller
Quinault Indian Nation
Portland Area Representative

James Crouch
Executive Director, California Rural Indian Health
Board, Inc.
California Area Representative

Valerie Davidson, TTAG Chair
Senior Director of Legal and Intergovernmental
Affairs, Alaska Native Health Consortium
Alaska Area Representative

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Billings Area Representative

Patrick Rock, MD
Executive Director Indian Health Board of
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Representative

H. Sally Smith
Chairman, Bristol Bay Health Area Health
Corporation
National Indian Health Board Representative

Donita Stephens
Finance Director, Choctaw Health Center
Nashville Representative

Alec Thundercloud, MD
Executive Director of Health, Ho-Chunk Nation
Bemidji Representative

Donald Warne, MD, MPH
Senior Policy Analyst, Great Plains Tribal Chairmen's
Health Board
Aberdeen Representative

Albuquerque Representative
Vacant



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Dedication

This *CMS American Indian and Alaska Native Strategic Plan* is dedicated to three colleagues whose contributions made the Tribal Technical Advisory Group (TTAG) stronger and more effective.

Robert Dean Moore, Rosebud Sioux (1963 - 2010)

Tribal Council member for the Rosebud Sioux Tribe, Robert Moore was the Aberdeen Area representative to the TTAG. Earlier in his career, as the Indian Affairs staff member for former U.S. Senator Tom Daschle, Robert raised awareness of health disparities and the need for long-term care for Tribal elders. He was a friend and warrior for all throughout Indian communities.

Kristine Anne Locke (1950 - 2012)

Technical Advisor to the Tribal Self Governance Advisory Committee (TSGAC) representative on the TTAG, Kris Locke brought technical expertise, wisdom and experience to the process of defining values and core principles, fostering team work among all participants, and providing technical and program support for TTAG subcommittees. She worked tirelessly on behalf of Tribes and American Indian and Alaska Native people.

Elmer Brewster, MSW, MPH, Paiute (1949 - 2012)

A friend to all who knew him, Elmer Brewster was engaged with the TTAG from its beginning, shared data and information about the costs of Indian health care, advocated for payment systems that were inclusive, and represented the Indian Health Service and the Indian health system honorably.



Executive Summary

- This is the third American Indian and Alaska Native (AI/AN) Strategic Plan for the Centers for Medicare and Medicaid Services (CMS) by the Tribal Technical Advisory Group (TTAG). Update of AI/AN Strategic Plan is urgently needed to address new opportunities and challenges of implementing legislation passed since the last Plan was written, including:
 - American Recovery and Reinvestment Act of 2009 (ARRA)
 - Patient Protection and Affordable Care Act (ACA), which also amended and permanently authorized the Indian Health Care Improvement Act (IHCIA)

- AI/AN Strategic Plan has **five goals that apply to all CMS programs**, including Medicare, Medicaid, CHIP, and Health Insurance Exchanges:
 1. CMS engages in meaningful **consultation** with Tribes and works closely with the TTAG. *(Page 12)*

 2. CMS enacts and implements **policy** through regulation, guidance, review and enforcement to align CMS programs to serve AI/ANs by improving enrollment processes, assuring access to care, having efficient payment systems, and increasing the I/T/U capacity to deliver integrated, comprehensive programs. *(Page 15)*

 3. CMS improves and expands opportunities for development and delivery of **Long Term Services and Support** throughout Indian communities. *(Page 19)*

 4. Through **outreach and enrollment** activities, all I/T/U programs are fully informed about CMS programs and AI/ANs know about benefits to which they are entitled. *(Page 22)*

 5. Develop and improve CMS **data systems to evaluate** and expand the capacity of CMS to serve American Indians and Alaska Natives. *(Page 25)*

- Annual budget for implementing the CMS AI/AN Strategic Plan is \$5.5 million in 2013, \$7.3 million in 2014, \$7.4 million in 2015, and \$4.5 million in the following 3 years. The higher amounts are needed in the next three years to **prepare for 2014** and on-going implementation to assure that AI/ANs benefit from ACA. Budget summary is provided in Appendix A *(Page 28)*.

- AI/AN Strategic Plan serves as an important reference document through the inclusion of Appendix B: **Legal Basis for Special CMS Provisions for American Indians and Alaska Natives**. *(Page 39)*.



Introduction

New developments require strategic response

This is the third *American Indian and Alaska Native Strategic Plan* that the Tribal Technical Advisory Group (TTAG) to the Centers for Medicare and Medicaid Services (CMS) has prepared to help guide Centers for Medicare & Medicaid Services (CMS). The first one was issued for the period of 2005-2010, and the second for the period of 2010-2015. There have been significant changes in the law and in CMS since the most recent strategic plan was issued in 2009, including:

- American Recovery and Reinvestment Act of 2009 (ARRA), P.L. 111-5, February 17, 2009.
- Patient Protection and Affordable Care Act (ACA), P.L. 111-148, March 23, 2010, which also permanently authorized the Indian Health Care Improvement Act (IHCA) by Section 10221.
- CMS Tribal Consultation Policy, signed Nov 17, 2011.
- The Supreme Court of the United States decision on June 28, 2012, that upheld the ACA, but created new challenges in the event that some states choose not to implement Medicaid Expansion.
- A prolonged period of an economic recession that has created pressures on State budgets that affect Medicaid program funding and services.
- Changes in direction by CMS to create a greater emphasis on payment related to quality, integration of services, utilization of electronic methods for enrollment and care management, and greater accountability.

This new *American Indian and Alaska Native Strategic Plan for 2013-2018* is urgently needed to:

- Get ready for 2014 when people will be able to enroll in the new Medicaid Expansion and Health Insurance Exchanges.
- Strengthen primary care networks to prepare for the managed care approaches across all CMS programs by facilitating the integration of Indian health providers, utilizing them as medical homes, acknowledging new provider types and services, and providing adequate payment for services.
- Build capacity for long term care through community based services and support in Tribal communities.
- Implement protections in the law for American Indians and Alaska Natives who enroll in federally-funded health programs.



- Create a partnership between CMS and Tribal governments that provides early discussions of policy development and planning to assure the integration of CMS programs and Indian health programs to create effective processes for enrollment, access to care, care coordination, quality care, and adequate payment for services.
- Reduce health disparities for American Indians and Alaska Natives which are among the worst of any racial or ethnic group in our nation, a condition that can be improved through better integration of the Indian health care system and CMS programs.

CMS programs must reduce health disparities

Federal funding for Medicaid, Medicaid Expansion, CHIP, Medicare, and Health Insurance Exchanges is intended to reduce health disparities in our society. At every stage of their lifespan, American Indians and Alaska Natives (AI/AN) have significantly worse health status than the rest of the nation.

A recent analysis of Medicaid data in one state¹ shows that infant mortality among AI/ANs was twice the rate for the Medicaid population as a whole. Compared to the rest of the world, the AI/AN infant mortality rate was higher in that State than such countries as Poland, Slovakia, Estonia, Malaysia, Thailand, and Sri Lanka. Contributing factors included deaths due to Sudden Infant Death Syndrome (SIDS) at a rate 3 times higher among Indians compared to the total Medicaid population, deaths due to injuries at a rate 5 times higher among Indians, and a rate of deaths from complications of pregnancy and delivery 50 percent higher than the total Medicaid population.

Medicaid data from the same state also provided an analysis of the risk factors that lead to poor pregnancy outcomes. Compared to all pregnant women on Medicaid, Indian pregnant women were 2.7 times more likely to have a mental health diagnosis, 3.3 times the rate of alcohol and substance abuse, a 70 percent higher rate of smoking, and a 30 percent higher rate of obesity.

CMS must assure that AI/ANs and Indian Health Service (IHS)/Tribal/and Urban Indian Organization (I/T/U) users are accurately identified in records for Medicaid, Medicare and Health Insurance Exchanges that can be used to calculate health disparities, as well as provide utilization data and performance metrics. In the past, IHS provided health status and health disparity information on a nationwide basis for AI/ANs who are I/T/U users; however, that effort was discontinued in 2007. According to the most recent reports from IHS, AI/ANs die at higher rates than other Americans from tuberculosis (500 percent higher), alcoholism (514 percent higher), diabetes (177 percent

¹ American Indian Health Commission for Washington State, Tribal Maternal and Infant Health Strategic Plan, 2010. Analysis based on 8 years of data by Laurie Cawthon, MD, MPH, Manager of First Steps Data Base in Washington State Department of Social and Health Services.



higher), unintentional injuries (140 percent higher), homicide (92 percent higher) and suicide (82 percent higher).² Current data are needed to know whether interventions, such as enrollment in CMS programs, are effective in changing health outcomes.

A number of factors contribute to persistent disparities in AI/AN health status. American Indians and Alaska Natives have the highest rates of poverty in America, accompanied by high unemployment rates, lower education levels, poor housing, lack of transportation and geographic isolation. All of these factors contribute to insufficient access to health services. American Indians and Alaska Natives continue to experience historical trauma from damaging federal policies, including those of forced removal, boarding schools, and taking of tribal lands, and continuing threats to culture, language, and access to traditional foods.

Historic and persistent under-funding of the Indian healthcare system has resulted in problems with access to care, and has limited the ability of the Indian healthcare system to provide the full range of medications and services that could help prevent or reduce the complications of chronic diseases. CMS, IHS and Tribes must work together to help eliminate existing health inequalities. Together we can and must strengthen the ability of Indian health programs to serve as the medical home for AI/ANs, offering culturally competent care with a public health focus, while fulfilling their important role as essential providers for Medicaid, Medicare, and Children Health Insurance programs and the prospective Health Insurance Exchange plans. This plan offers CMS and TTAG a roadmap for making that happen.

The Indian health care system is unique

The United States has acknowledged its special trust responsibility to provide health services to AI/ANs. This responsibility is the direct result of treaties between the United States and Indian Tribes and of executive orders, and has been reaffirmed by judicial decisions, executive orders, and Acts of Congress (see Appendix B, p. 38).

The IHS was created in 1955 to assist the United States to fulfill its obligation to provide health care to AI/ANs. Twenty years later, Congress enacted the Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638) to enable Tribes and Tribal Organizations to directly operate health programs that would otherwise be operated by IHS, thereby empowering Tribes to design and operate health programs that are responsive to community needs. Title V of the Indian Health Care Improvement Act of 1976 (P.L. 94-437) (IHCIA) authorized federal funding for urban Indian organizations to provide health

² Website <http://www.ihs.gov/PublicAffairs/IHSBrochure/Disparities.asp>. AI/AN data from 2004-2006 are compared with U.S. All Races data for 2005.



services to AI/ANs, many of whom had been relocated to urban areas by federal relocation programs. Taken together, this complex healthcare delivery system is often referred to as the “I/T/U” (IHS/Tribal/Urban) or Indian healthcare system. A year later, the Congress authorized IHS and tribal health programs to bill Medicare and Medicaid, which expanded the resources available to them to carry out the federal trust responsibility.

Today the Indian healthcare system includes 46 Indian hospitals (1/3 of which are tribally operated) and nearly 630 Indian health centers, clinics, and health stations (80 percent of which are tribally operated). When specialized services are not available at these sites, health services are purchased from public and private providers through the IHS-funded Contract Health Services (CHS) program. Additionally, 34 urban programs offer services ranging from community health to comprehensive primary care.

The I/T/U utilizes a community-based public health model with many approaches that are not found in typical American medical delivery systems. For example, the Indian health programs include public health nursing, outreach workers, prevention services, and even building community water and sanitation services. Indian health programs have pioneered new types of providers, such as community health aides and dental health therapists, as well as new approaches to delivering services in remote rural areas, including telehealth. Tribal governments manage a wide range of services, such as substance abuse treatment, the U.S.D.A. nutrition programs for pregnant women, infants and children (WIC), Senior Centers and elder nutrition sites, rabies vaccinations for dogs, and injury prevention programs, to name just a few. Tribal programs tend to take a more holistic view and utilize indigenous people who speak the local language and live in remote Tribal communities.

Not only does the Indian health system have to deal with health disparities, it’s important to note that the system is also challenged with funding disparities. The IHS Federal Disparity Index (FDI) is used to determine the level of funding for the Indian health system relative to its total need. The FDI compares actual health care costs for an IHS beneficiary to those costs of a beneficiary served in mainstream America. The FDI uses actuarial methods that control for age, sex, and health status to price health benefits for Indian people using the Federal Employee Health Benefits (FEHB) plan, which is then used to make per capita health expenditure comparisons. Based on this model it is estimated that Congress provides direct appropriations to the Indian health system, on average, at approximately 60 percent of its level of need.³ It is these health and funding disparities that exacerbate the challenges in providing health care for AI/AN people.

³ The IHS calculates funding needs for IHS and tribal health programs by “comparing [IHS] funding to the cost of providing medical insurance for [AI/AN] users in a mainstream health insurance plan such as the Federal Employees Health Plan (FEHP).” *Indian Health Manual*, Part 6, Chapter 4, Manual Exhibit 6-4-A. This methodology



The federal government reimburses States 100 percent for Medicaid services delivered to AI/ANs through IHS and Tribal health programs. States are reimbursed for payments made to Urban Indian Health Programs for Medicaid services provided to AI/ANs on the basis of the state-specific Federal Medical Assistance Percentage (FMAP), which in 2013 varies from a minimum of 50 percent up to 73.43 percent. Many programs operated by the IHS and Tribes use a bundled rate approved by the Office of Management and Budget (OMB) on an annual basis, called the “IHS Reimbursement Rate” or the “IHS encounter rate.” These and other unique circumstances and billing practices are generally not well understood outside the Indian health system. A summary of the legal basis for special CMS provisions for American Indians and Alaska Natives has been updated and presented in Appendix B (page 38). The lack of 100 percent FMAP to States for services provided in Urban Indian Health Programs has precluded these programs from inclusion in the “IHS encounter rate” reimbursement methodology, and hinders the recognition by States of the special obligations owed to urban Indians and Urban Indian Health Programs under Federal law. There is much more work to be done to align the policies, programs, and systems for billing for CMS services in order to ensure that AI/ANs have the health care coverage they are entitled to receive.

Tribal consultation is required for CMS programs

The United States government has a unique legal and political relationship with American Indian and Alaska Native Tribes. This special relationship recognizes Tribes as sovereign nations that retain the inherent right to self-govern, and that interact with the United States on a government-to-government basis. These rights are grounded in the U.S. Constitution and treaties, and are reinforced by judicial precedent and Presidential Executive Orders that direct federal agencies to consult with Tribes on a government-to-government basis. Tribal consultation is an open and continuous exchange of information that leads to mutual understanding and informed decision making between federal agencies and tribal governments. Tribal consultation should occur at the earliest possible point in the policy formulation process, particularly whenever decisions would significantly impact Tribes, would have a substantial compliance cost, or would result in new or changed policies. Both the Department of Health and Human Services (HHS) and CMS have Tribal consultation policies, and CMS is developing procedures to operate those policies. The CMS Tribal Consultation policy calls for an annual review and revisions to update the policy.

The purpose of the first goal of this Strategic Plan is to ensure meaningful consultation with Indian Tribes on policy and programmatic issues including, but not limited to eliminating health disparities of Indians and ensuring access to critical health services, including those made available through Medicare,

is commonly referred to as the Federal Disparity Index (FDI). Available at:
<http://www.ihs.gov/NonMedicalPrograms/Inf/>



Medicaid, CHIP, and Exchange Plans administered by CMS. The involvement of Tribes and the TTAG in the development of CMS policy allows for culturally appropriate approaches resulting in greater access to CMS programs and positive outcomes for Indian people and the health programs operated by the Indian Health Service, Tribes and Tribal Organizations, and urban Indian organizations.

Tribal Technical Advisory Group advises CMS

The Tribal Technical Advisory Group (TTAG) was started by CMS in 2004 as a policy advisory body. In 2009, ARRA Section 5006(e)(1), P.L. 111-5 established the TTAG in law, added new categories of members, and reaffirmed its status as exempt from the Federal Advisory Committee Act (FACA), 5 U.S.C. App. 2

TTAG has 17 members: elected tribal leaders (or their designated employees) selected from the 12 Areas of the IHS, as well as representatives from the National Congress of American Indians (NCAI), the National Indian Health Board (NIHB), the Tribal Self-Governance Advisory Committee (TSGAC), the Indian Health Service, and the National Council of Urban Indian Health (NCUIH). TTAG meetings, subcommittees, and workgroups facilitate the exchange of information and perspectives on the administration of CMS programs and their efficacy in Indian communities. TTAG meetings complement, but do not supplant, tribal consultation processes that take place between CMS and individual Tribes.

Some of the recommendations from the TTAG have been implemented as CMS regulation and policy, and later reaffirmed in federal law. While the TTAG has offered their advice to CMS on a wide range of issues, the following are some of the significant achievements:

- CMS Tribal Consultation Policy is adopted and training is provided for CMS employees to implement it.
- Native American Contacts (NACs) are designated for each Regional Office of CMS.
- Medicaid Administrative Match may be made available by State Medicaid programs to Tribal health programs to provide enrollment assistance.



- Indian Addendum⁴ developed for Medicare Part D to assure participation by I/T/U pharmacies on terms appropriate to their governmental status and statutory protections.
- Successful campaign is initiated to increase AI/AN enrollment in CHIP.
- On April 6, 2012, CMS approved Arizona’s request to amend its 1115 demonstration known as the Arizona Health Care Cost Containment System (AHCCCS), which allows the State to offer uncompensated care payments to Indian Health Service and tribally-operated facilities. Under the amended demonstration, IHS and Tribal facilities can begin to claim payments for uncompensated care costs associated with services furnished to individuals with income up to 100 percent of the FPL.
- CMS training is provided to I/T/U in each Area on an annual basis, supplemented by Medicine Dish programs, All Tribes calls, a CMS Day at the NIHB Annual Consumer Conference, CMS sponsorship of a Long Term Care Conference and a website.
- Meaningful use of electronic health records rules are defined and promote I/T/U participation.
- States are required to consult with Tribes and Tribal Organizations on Medicaid State Plans, waivers and the development of health insurance exchanges.
- Regulation tracking process is implemented for AI/AN and I/T/U issues.
- CMS Tribal Affairs Group added staff to address issues.
- Medicaid, CHIP, and Medicare enrollment, service and payment data for AI/AN have been identified and reported .

Collaborative policymaking processes such as those demonstrated by TTAG improve the quality of resultant decisions.

Organization of CMS AI/AN Strategic Plan

⁴ “Indian Addendum” refers to contract terms that are specific to IHS and tribal health programs that was approved by CMS and that Medicare Part D pharmacy plans must include in preferred provider arrangements with IHS and tribal health programs.



This plan is organized to provide a focus on the goals and objectives. Supporting documentation and budget summaries are provided in appendices. There are five overarching goals in this plan that apply to all CMS programs, including Medicare, Medicaid, CHIP, and Health Insurance Exchanges. These are:

Goal 1: CMS engages in meaningful **consultation** with Tribes and works closely with the TTAG.

Goal 2: CMS enacts and implements **policy** through regulation, guidance, review and enforcement to align CMS programs to serve AI/ANs by improving enrollment processes, assuring access to care, having efficient payment systems, and increasing the I/T/U capacity to deliver integrated, comprehensive programs.

Goal 3: CMS improves and expands opportunities for development and delivery of Long Term Services and Support (**LTSS**) throughout Indian communities.

Goal 4: All I/T/U programs are fully informed about CMS programs and AI/ANs know about benefits to which they are entitled.

Goal 5: Develop and improve CMS **data systems to evaluate** and expand the capacity of CMS to serve American Indians and Alaska Natives.

For each goal, a number of objectives are listed with tasks identified that are necessary to achieve each objective.

Budgets for each of the tasks are estimates based on experience and have not been calculated based on actual or projected costs. For items related to policy development, it is assumed that CMS staff is already funded. It should be noted that the budgets do not consider the time and expenses of TTAG members, alternates and their technical advisors who participate in TTAG meetings, subcommittee meetings, teleconferences, and other activities.



Goal 1: CMS will execute its federal trust responsibility to engage in meaningful consultation with Tribes and work closely with the Tribal Technical Advisory Group.

Objective 1a – On an annual basis, CMS will engage the TTAG to evaluate and revise the CMS Tribal Consultation Policy

Task 1: Evaluate and revise existing CMS Tribal Consultation Policy, in collaboration with the TTAG and CMS Tribal Affairs Group (TAG), and provide an opportunity for Tribal consultation on the policy.

Task 2: CMS will conduct an annual Tribal Consultation session separate and distinct from the HHS Department-wide and Regional Tribal Consultation session.

Budget request: \$75,000 per year

Task 3: In partnership with TTAG and IHS, CMS will develop a written annual report documenting and evaluating consultation activities, which will be disseminated to partners in the first quarter of each fiscal year. The report will assess both consultation processes and outcomes. This detailed report will be used by TTAG to monitor and evaluate consultation processes and their impact.

Budget request: \$40,000 per year. These funds will be used to support tracking activities by CMS and process evaluations carried out by a qualified tribal consultant/organization, and review of the report with relevant stakeholders.

Objective 1b – In collaboration with the TTAG, CMS will develop mechanisms to involve Tribes in states that have federally-facilitated exchanges and partnership exchanges to assure that I/T/U issues are addressed in the planning, policies, structure, and operations of those exchanges.

Task 1: Beginning in 2012, CMS and TTAG will agree on a list of issues that could affect AI/AN participation in health insurance exchanges and create workgroups that meet regularly to resolve those issues prior to July 2013.

Objective 1c – Each year, CMS will provide financial and administrative support to facilitate the ongoing activities of TTAG, and a sufficient budget to support TTAG activities included in the 2013-2018 Strategic Plan.

Task 1: CMS will fully fund the Tribal Technical Advisory Group, including TTAG travel, per diem, communication needs, basic staffing, and other related expenses for face-to-face meetings up to



three times per year. TTAG serves as a policy advisory body to CMS, providing expertise on policies, guidelines, and programmatic issues affecting the delivery of health care for AI/ANs.

Budget request: \$280,000 per year. Funds will be used to support the travel and per diem expenses of TTAG members three times per year, occasional subcommittee meetings, and the ongoing communication and professional technical assistance needed to support TTAG meetings and activities.

Task 2: CMS will actively seek to recruit AI/ANs for key policy positions, particularly with regard to Indian health care. CMS will develop a personnel succession plan to ensure consistent and competent TAG staffing with expertise in the Indian healthcare system. The personnel succession plan should include recruitment, training, and promotion strategies, particularly for AI/ANs, including internships, cross-training opportunities for IHS employees, recruitment of AI/ANs to serve as Native American Contacts (NACs) in regional offices, and/or providing executive leadership training for AI/ANs in CMS.

Budget request: \$25,000 per year for succession planning and recruiting as needed.

Task 3: The Tribal Affairs Group (TAG) at CMS will report quarterly to TTAG activities and funding for implementation of this Strategic Plan.

Task 4: CMS will retain at least 7 FTE personnel in their TAG who will provide policy and administrative support to TTAG. CMS will hire and retain Native American Contacts in each of its Regional Office locations.

Objective 1d – CMS personnel with the authority to make binding decisions will regularly participate in TTAG meetings, the Annual HHS Budget Consultation session, and HHS regional tribal consultation meetings and listening sessions.

Task 1: On an annual basis, the CMS Administrator, and/or CMS Center and Office Directors, will participate in at least three face-to-face meetings with TTAG, along with other CMS officials with pertinent expertise in the subject matter at hand.

Task 2: Key leadership from CMS Headquarters will attend annual HHS regional tribal consultation meetings and listening sessions.

Objective 1e – CMS will develop a set of standard operating procedures that will be used by the agency to guide administrative decisions regarding Indian health policy.

Task 1: In recognition of the United States trust responsibility described in Appendix B (p. 38), TTAG and the CMS Office of External Affairs will work collaboratively to develop a set of standard operating procedures that can be used by CMS to guide policy formation and Tribal consultation.



Such procedures should be based on values and principles that promote the federal trust responsibility for health care and Tribal consultation.

Budget request: \$40,000 for the first year to develop the standard operating procedures. Funds will be used to support the completion of this task by a qualified consultant or Tribal Organization, and any partner meetings needed to develop mutually agreed upon standard operating procedures. An additional \$15,000 per year is requested to monitor compliance and evaluate the effectiveness of the standard operating procedures.

Examples of such values and principles include:

- CMS recognizes that the tribal healthcare delivery system is politically, legally, and culturally unique and that policies developed specifically for Indian healthcare can be designed to apply only to Indian health programs, and will not be considered to set precedent for other types of healthcare delivery system.
- It is a well-settled canon of construction that federal laws enacted for the benefit of Indian Tribes are to be given a liberal interpretation, and that doubtful expressions are to be resolved in favor of Indian interests.
- Absent express statutory prohibition, CMS shall engage in Tribal consultation and implement Tribal recommendations made during such consultations, regarding any CMS policies and actions that:
 1. Have Tribal implications, or
 2. Have substantial direct effects on
 - a. one or more Indian Tribes, or
 - b. the relationship between the Federal Government and Indian Tribes, or
 - c. the distribution of power and responsibilities between the Federal Government and Indian Tribes.
- CMS will develop enrollment strategies that maximize AI/AN participation in Medicaid, Medicare, and CHIP, and health insurance exchanges, and will work collaboratively with I/T/Us to carry out identified strategies.



Goal 2: CMS enacts policy through regulation, guidance, review and enforcement to align CMS programs to serve American Indians and Alaska Natives by improving enrollment processes, assuring access to care, having efficient payment systems, and increasing the I/T/U capacity to deliver integrated, comprehensive programs.

Objective 2a – CMS will work with the TTAG to develop a global approach to funding enrollment assistance provided by the I/T/U and eligibility determinations for all CMS supported programs.

Task 1: Evaluate the number of States that are using Medicaid Administrative Match (MAM) to fund enrollment assistance at I/T/Us and the number of I/T/U programs that are receiving this funding, and the best approaches to provide financial support (including expansion of MAM to other I/T/Us and broadening the programs for which its funding can be used) for assisting AI/ANs who use I/T/U programs to enroll in Medicaid, Medicaid Expansion, CHIP, qualified health plans through the health insurance exchange, and other insurance and benefits (including those provided by the Department of Veterans Affairs), and other new approaches for simplifying applications and approvals for enrollment within control of CMS.

Task 2: Develop mechanisms for the I/T/U to receive Navigator or other funding from the federally-facilitated Exchanges, partnership exchanges and state exchanges.

Task 3: Consider alternative sources of funding for the I/T/U to assist AI/ANs to enroll in CMS funded programs, including Medicaid, Medicare, CHIP, and qualified health plans offered through exchanges, including special enrollments that may be offered to eligibles.

Task 4: Streamline systems to offer aggregate payment options and remove any barriers to Tribes and others paying premiums for enrollment in federally-funded programs, including Medicare, Basic Health Plans, and Health Insurance Exchanges.

Objective 2b – To maximize access to care and coordination of services for AI/ANs, CMS will work with the TTAG to develop processes to assure that I/T/Us can choose to be network providers for managed care organizations that deliver services with funding from Medicare, Medicaid, CHIP and Health Insurance Exchanges.

Task 1: CMS will work with the TTAG to develop a prototype Indian Addendum that can be used with managed care provider contracts in all programs of CMS to acknowledge the federal laws that are specific to the I/T/U and that can affect provider contracts.

Task 2: CMS will adopt standards of network adequacy for managed care organizations that are federally-funded (in whole or part) that require inclusion of I/T/Us as sources of care that are geographically accessible and culturally appropriate.



Task 3: CMS will review programs, policies, and payment mechanisms and provide training and technical assistance to assure that each I/T/U can be the medical home for the AI/ANs who use its services.

Task 4: CMS will assure that all AI/ANs who are enrolled in a managed care organization through Medicare, Medicaid, CHIP or Health Insurance Exchanges can be referred to specialty care by I/T/U providers and that the laws and protections regarding deductibles and co-pays for AI/AN are followed.

Objective 2c – CMS will assure that I/T/Us are paid for all services that are covered by CMS supported programs and provided to any AI/AN who is enrolled in Medicaid, Medicaid Expansion, Basic Health Plans, Medicare, and Health Insurance Exchanges.

Task 1: CMS will enforce the laws that assure that I/T/Us are paid for off-plan services delivered by it or an I/T/U provider to an AI/AN enrolled in a federally funded program by

- assuring that this requirement is included in contracts with managed care organizations and preferred provider arrangements,
- providing a point of contact for I/T/U programs that are not able to receive payment for services that have been billed,
- informing the managed care or preferred provider organization of its obligation to pay for these services, and
- cancelling or not renewing contracts with managed care or preferred provider organizations or qualified health plans that do not abide by the applicable statutory and contractual and requirements.

Task 2. CMS will sponsor a conference to engage Tribal technical advisors and others in a better understanding of emerging payment approaches in Medicare and Medicaid, analyze how those approaches may affect I/T/U participation and revenues, and share that information with I/T/U management.

Budget: \$120,000 in 2013.

Task 3: All CMS programs will review their payment policies for telehealth services and work with the TTAG to update those policies to assure that I/T/Us can be paid for telehealth services.

Task 4: CMS will resolve the problem of paying for Medicaid services for AI/AN youth who are receiving treatment and/or enrolled in boarding schools in a state other than where their parents are resident (Across State Borders).

Task 5: CMS will create a workgroup across all CMS programs and with the TTAG to develop criteria for I/T/U providers as distinct provider types for enrollment in Medicare and in State



Medicaid programs in order to achieve greater flexibility for services and distinct payment methodologies.

Objective 2d – The CMS Office for Dual Eligibles will work with a subcommittee of the TTAG to assure that I/T/Us can participate in new approaches for coordinating services to and associated payments for people who are dually eligible for Medicaid and Medicare, and in some cases also eligible for services from the VA.

Task 1: TTAG will form a subcommittee to work with the Office for Dual Eligibles on planning new programs, enrollment policies, and payment approaches appropriate for I/T/Us.

Objective 2e – CMS and the TTAG will work together to assure that AI/AN continue to receive needed services and the I/T/U continues to receive payment for those services In the context of States reforming their Medicaid programs, creating new types of waivers, choosing whether to implement Medicaid Expansion, and eliminating CHIP programs.

Task 1: CMS will provide information and technical assistance to Tribes and States to allow them to adopt the principles and approaches used in the Arizona Medicaid waiver that preserves services for AI/ANs.

Task 2: CMS will notify Tribes affected by State reforms to their Medicaid programs and consult with Tribes as soon as practicable on State Medicaid reform proposals.

Task 3: CMS will, as a condition of approving any State reform proposal, require the State to design its proposal to ensure continued AI/AN access to existing covered services and I/T/U payment for those services.

Objective 2f – Offices within CMS that are responsible for enforcement and compliance will work with the TTAG to develop approaches for assisting I/T/Us adhere to applicable laws and regulations, to develop adequate compliance systems, and to resolve compliance issues.

Task 1: The CMS TAG will provide training on Indian health care delivery systems to offices responsible for enforcement. Such training will include material regarding the unique legal and regulatory environment in which I/T/Us carry out their programs.

Task 2: CMS will expedite consideration of recommendations regarding Safe Harbors submitted by Tribes and Tribal Organizations to assure that there is appropriate coordination between health care delivery systems without violations of the law.

Task 3: CMS will work with the TTAG to develop appropriate policies for compliance that consider the budgets, size, location, and staffing of I/T/U programs and to develop tiered standards that do not unreasonably take resources from direct patient care to comply with CMS requirements for accountability.



Task 4: CMS will provide training, technical assistance, and funding for systems' improvements to I/T/Us to assist them to comply with policies with regard to disclosure and auditing.

Objective 2g– CMS will facilitate implementation of ARRA Section 5006 that authorizes American Indian Medicaid Managed Care Entities.

Task 1: CMS will sponsor a meeting with Tribes, Tribal Organizations, urban Indian organizations, and others to share information, provide technical assistance, and identify next steps for implementing the creation of American Indian Medicaid Managed Care Entities under Section 5006 of ARRA.

Budget request: \$150,000 per year in 2014 and 2015.

Objective 2h – CMS will create internal processes and funding to facilitate partnerships with Tribes, Tribal Organizations, and urban Indian organizations to work together on new policies and approaches to better align CMS and I/T/U programs.

Task 1: CMS will substantively involve TTAG in administrative, regulatory, and legislative policy questions before the notice of proposed rule-making (NPRM) and provide funding for a policy analyst to track NPRMs, determine whether proposed rules are relevant to Indian health care, provide information to the TTAG about the potential impacts of regulations, track TTAG comments on NPRMs, and track final regulations to see if they have been responsive to TTAG recommendations.

Budget request: \$250,000 per year

Task 2. CMS will create better mechanisms to fund cooperative agreements with Tribes, Tribal Organizations, and urban Indian organizations to provide policy analysis, outreach and education to assist CMS to carry out its mission to improve the health status of AI/ANs through better access to care and quality of care.

Task 3. The CMS Office of Legislation will work with Tribes, Tribal Organizations, and urban Indian organizations on mutually beneficial legislation, including revisions to the Affordable Care Act to clarify the definition of Indian and to address issues related to Medicaid Expansion that were created by the Supreme Court decision.

Task 4. CMS will move the Tribal Affairs Group from the Office of Public Engagement to the Office of the Administrator to more accurately reflect its role in policy development across all CMS agencies.



Goal 3: Improve and expand the development and delivery of Long Term Services and Support throughout Indian communities.

Objective 3a - Develop and maintain an interactive data base of current Long Term Services and Supports (LTSS) provided by the Indian Health Service, tribal health programs, and urban Indian organizations with contact information for the providers. Develop toolkits to assist other health programs to evaluate options and develop similar programs. In addition, CMS working with IHS and the Administration for Community Living (ACL) in HHS will provide technical assistance to I/T/Us developing and taking advantage of these LTSS programs

Task 1: Working with ACL and IHS, CMS will develop and maintain a website that will serve as an AI/AN LTSS portal to:

1. Facilitate a learning community for the sharing of knowledge and expertise among I/T/U health programs by:
 - a. Posting lists of existing programs and contacts for each;
 - b. Posting technical assistance resources, information, and links;
 - c. Hosting web-based seminars and conference calls;
 - d. Posting inventory of State Medicaid Plans and waivers that address LTSS in states where I/T/U programs are located and updating the inventory at least annually;
 - e. Research and post “best practices” and models for successful LTSS programs, including an analysis and description of prior Elder Care Initiative projects;
 - f. Providing information to I/T/Us about training and technical assistance resources and potential funding opportunities.
2. Provide an actively moderated listserv that will make available:
 - a. A forum for communication among CMS, IHS, and ACL with I/T/Us as they develop LTSS; and
 - b. A forum for communication and sharing among I/T/U programs

Budget request: \$125,000 in 2013 and \$100,000 per year in 2014 and 2015.

The website will identify current opportunities and barriers for operation and development of LTSS communities where I/T/U programs operate, and present “best practices” or models of



successful LTSS programs in such locations and information about how I/T/U programs participate in these LTSS programs.

Note: In 2011 the Agency on Aging (AoA), IHS and CMS signed a Memorandum of Understanding (MOU) to establish a coordinated effort between the agencies to develop methods and means for providing technical support to I/T/Us in order to expand development and delivery of LTSS in Indian communities.

Task 2: CMS will work with the TTAG, IHS, and the Administration for Community Living to develop technical assistance materials for I/T/Us that want to develop and take advantage of these LTSS programs.

Objective 3b - CMS will develop an AI/AN *LTSS Delivery Plan* and a *LTSS Roadmap* (formerly Toolkit) for I/T/Us to provide information and guidance to I/T/Us wishing to research the possibilities of implementing LTSS programs in their communities.

Task 1: CMS will work with TTAG and IHS to:

- Assist I/T/Us to assess their current LTSSs and to identify internal and external barriers to optimal operation and expansion;
- Develop an *AI/AN LTSS Service Delivery Plan* containing strategies to overcome existing administrative or regulatory policy barriers for the implementation of LTSS in Indian communities, including practical guidance from I/T/Us that have already developed certain services; and
- Develop recommendations on how to engage States and CMS for financing LTSS in Indian communities.

Task 2: Working with TTAG, IHS, and ACL, CMS will develop a searchable web tool (*LTSS Roadmap*) as a part of the website development in Objective 3a for use by I/T/Us in the development of LTSS programs. The Roadmap will include information on LTSS that are accessible and/or covered under State Plans and waivers, and will include options available to I/T/Us to overcome barriers and improve access to LTSS and financing.

Budget request: \$150,000 per year in 2013, 2014, and 2015.

Objective 3c - Throughout the next five years, CMS and TTAG will work collaboratively to educate tribal leaders about long term care program planning and implementation, particularly regarding services that address the needs of elders, veterans, and persons with disabilities.

Task 1: CMS and TTAG will review annually documents that describe overarching principles and talking-points, regarding the importance of LTSS for AI/ANs in Indian communities and other communities where I/T/Us are located and delivery by I/T/U programs, controlling the cost and



improving the quality of LTSS programs supported with Federal funds, including Medicare and Medicaid.

Task 2: On a quarterly basis, CMS and TTAG will develop audience-specific educational materials for I/T/U leadership and staff that describe strategies to achieve increased access to LTSS in Indian communities and other communities in which I/T/U programs are located and will disseminate these materials to tribal leaders and I/T/U staff.

Budget request: \$100,000 per year. These funds will cover formative research, media design, printing, and dissemination.

Task 3: On an annual basis, CMS will work with TTAG and IHS to identify existing meetings or conferences that are attended by I/T/U leaders and staff, at which workshops or presentations could be provided on LTSS services in Indian communities and other communities in which I/T/U programs are located. When appropriate, experts in this field will provide workshops or presentations.

Budget request: \$100,000 per year. These funds will cover travel, per diem, and registration expenses for CMS, Tribal and/or expert presentations at five or more national meetings/conferences.

Task 4: ACL, IHS, and CMS will jointly develop and support an annual *AI/AN LTSS Conference* for experts to provide education on LTSS and allow I/T/U LTSS programs to share their experiences, showcase best practices, and enhance the LTSS' learning network.

Budget request: \$200,000 per year in 2013, 2014, and 2015. These funds will cover conference planning, facility costs, speaker fees, travel, and registration expenses for a national AI/AN LTSS conference.

Task 5: From 2013-2017, CMS will fund a resource center to build capacity for LTSS for 15 Tribes, by assisting them with planning and development grants, and providing teams of experts to evaluate their existing LTSS, developing specific steps to integrate and expand necessary LTSS, and providing program specific assistance in overcoming barriers to accomplishing the steps.

Budget request: \$300,000 in 2013; \$1.5 million per year in 2014 and 2015



Goal 4: Every Indian Health Service, tribal and urban Indian health program is fully informed about CMS programs and every American Indian and Alaska Native knows about the benefits to which they are entitled.

Objective 4a – Maintain effective communications between CMS and Tribes and I/T/U health programs.

Task 1: CMS will work with the TTAG and its Outreach & Education subcommittee to design and implement a communications plan each year that facilitates a better understanding of CMS programs among I/T/U providers.

Budget request: \$25,000 per year

Task 2: CMS will use national Indian organizations such as the National Indian Health Board (NIHB), the National Congress of American Indians (NCAI), National Council of Urban Indian Health (NCUIH), and the Tribal Self-Governance Advisory Committee (TSGAC) to share CMS information with Tribal governments and I/T/U health programs via established communication channels, such as newsletters, websites, e-mails, and meetings.

Budget request: \$150,000 per year. Funds will be used to sponsor national and regional Tribal Organizations to disseminate CMS information via established communication channels.

Task 3: At the request of area and national Indian organizations, CMS will participate in tribal meetings, such as: the CMS Day at the National Indian Health Board’s Annual Consumer Conference; the annual meetings for the National Congress of American Indians, Tribal Self Governance, Direct Service Tribes, and Urban Indian Clinics; meetings of Area Indian Health Boards; and tribal consultation meetings.

Budget request: \$150,000 in 2013, \$175,000 in 2014, \$175,000 in 2015. Funds will be used for sponsorship and to support registration, exhibit costs, and travel expenses.

Task 4: CMS should contract with Area Indian Health Boards and other organizations of I/T/U programs to publicize CMS trainings and provide travel assistance for tribal participation in regional trainings.

Budget request: \$240,000 in 2013, \$240,000 in 2014, \$250,000 in 2015. Funds will be used by regional and national tribal organizations to publicize CMS meetings and facilitate tribal participation in regional trainings.



Objective 4b – Provide information, training, and capacity building assistance to the I/T/U regarding CMS programs.

Task 1: In collaboration with TTAG, CMS will develop and implement an annual training plan for I/T/U providers using appropriate Information Technology (IT) communication systems, such as webinars, Medicine Dish programs, YouTube videos, and other social media.

Budget request: \$100,000 in 2013, \$150,000 in 2014, \$200,000 in 2015.

Task 2: CMS will hold 20 training meetings per year to provide information about Medicare, Medicaid, CHIP, and Health Insurance Exchanges to I/T/U employees to improve their provision of CMS services and increase enrollment of AI/AN beneficiaries.

Budget request: \$750,000 per year. These funds will be used to contract with Area Health Boards to hold annual trainings and meetings for I/T/U employees.

Task 3: CMS will develop, maintain, and update web based manual of CMS policies and guidance that are specifically related to AI/AN and the I/T/U.

Budget request: \$100,000 in 2013, \$125,000 in 2014, and \$150,000 in 2015.

Task 4: *All Tribes Calls* will be scheduled by TAG specifically for issues related to Indian healthcare at least 6 times per year, with TTAG assisting in developing topics for the calls.

Budget request: \$100,000 per year.

Task 5: CMS and its contractors will provide tribal-specific ICD-10 training in each of the 12 Areas of the Indian Health Service, and other coding training as needed.

Budget request: \$200,000 in 2013, \$750,000 in 2014, \$850,000 in 2015.

Objective 4c – Provide training and technical assistance for I/T/U programs to maximize enrollment of eligible AI/ANs in Medicaid, Medicaid Expansion, Medicare, CHIP, and Health Insurance Exchanges.

Task 1: CMS will provide training and technical assistance to I/T/Us and States to improve access to sustainable sources of compensation for I/T/Us to provide enrollment assistance to AI/ANs for CMS programs, such as Medicaid Administrative Match (MAM), and Navigator funding for Exchange enrollment.

Budget request: \$100,000 per year.

Task 2: CMS will provide training and technical assistance to I/T/Us and States to increase utilization by I/T/Us of electronic enrollment applications and determinations, and new approaches to simplification of enrollment processes.

Budget request: \$500,000 per year.



Task 3: CMS, in collaboration with TTAG, will develop a simple and practical handout for use by I/T/U personnel, States, and other entities providing enrollment assistance to AI/ANs that explains the special provisions they qualify for because of their status as AI/ANs in CMS programs.

Budget request: \$125,000 in 2013, \$200,000 in 2014, \$125,000 in 2015.

Objective 4d – Provide materials and marketing designed to inform American Indians and Alaska Natives about CMS programs for which they may be eligible.

Task 1: CMS will develop, design, produce, and disseminate materials that are culturally appropriate and effective in AI/AN communities, with an emphasis on the new Medicaid Expansion and Health Insurance Exchanges, by:

- Hiring graphic artists who are AI/AN
- Developing a television campaign with AI/AN images and messages that are appropriate for people using Indian health programs
- Developing radio programs for tribal radio stations
- Placing materials in effective communication channels
- Translating materials as needed

Budget request: \$500,000 per year.



Goal 5: Develop and Improve CMS data systems to evaluate and expand the capacity of CMS to serve American Indians and Alaska Natives.

Objective 5a – CMS will create data systems that identify AI/AN appropriately to assure that they are provided the benefits and protections under laws and regulations (such as waiver of co-payments and deductibles) under Medicaid, CHIP, Basic Health Plans, and Health Insurance Exchanges.

- Task 1:** CMS and TTAG will create a joint workgroup on Data and Policy to assure that AI/AN provisions of ARRA and ACA, as well as other laws and regulations, are implemented in the eligibility and enrollment processes, including designating and implementing the federal data hub for eligibility; to assure that computer systems used by providers flag AI/AN cost sharing protections; and to appropriately designate AI/ANs for reporting and performance metrics, including assessing levels of enrollment.
- Task 2:** Twice a year CMS will hold a day of meetings at CMS central offices in Baltimore for TTAG Data and Policy Subcommittee members to exchange information with key CMS staff in policy implementation, data systems, and innovations to understand the changes that are occurring with the implementation of health care legislation and how they could affect AI/AN enrollment and I/T/U provider participation in CMS programs.
- Task 3:** The attendees will make recommendations to the CMS TTAG regarding approaches needed to change CMS and other data collection systems for implementation of health care legislation and suggest topics on the effects on AI/AN and I/T/U for follow-up.
- Task 4:** Make the CMS data and any findings from the data systems available online, in presentations at AI/AN and CMS conferences, and in reports, so that AIAN stakeholders can use the data and findings.

Budget request: \$150,000 per year for Objective 5a.

Objective 5b – Develop and improve data for AI/AN populations within and outside of the IHS healthcare delivery system that can be used to evaluate CMS program enrollment, health care delivery, outcomes, and payments across states and IHS Areas during the implementation of ACA, CHIPRA, ARRA, and any subsequent health care policy changes.

- Task 1:** Establish baseline enrollment rates in CMS programs and federally facilitated Health Insurance Exchanges for AI/ANs and monitor changes in the rates.



Task 2: Establish baseline usage indicators for CMS program health care services used by AI/ANs and monitor changes in the usage.

Task 3: Determine health outcomes in CMS programs of care for AI/ANs.

Task 4: Establish baseline CMS program payments for health care for AI/ANs and monitor changes in the payments.

Task 5: Make the evaluation data sets and findings available online, in presentations at AI/AN and CMS conferences, and in reports, so that AIAN stakeholders can use the data and findings.

Budget request: \$300,000 per year for Objective 5b.

Objective 5c – Produce an AI/AN CMS Data Symposium on the impact of the implementation of ACA, CHIPRA, ARRA, and any subsequent health care policy changes on AI/AN and I/T/U providers.

Task 1: CMS will sponsor a one-day Data and Policy Conference bringing together experts in demographic, services, and policy analysis from outside CMS to better understand the impacts of the legislative health care reforms relevant to AI/AN and I/T/U providers.

Task 2: Conduct conference planning sessions with CMS staff, and secure the necessary personnel, materials, facilities, and equipment to accomplish the tasks needed to plan, prepare, and execute the Conference including making site arrangements for the event and travel arrangements for speakers.

Task 3: Provide brief descriptions of three research projects that could be carried out using the American Indian specific data developed to date that might have utility to Tribes, IHS funded health providers, state Medicaid programs or Health Benefit Exchanges.

Task 4: Provide a technical writer for the symposium who shall prepare a draft Data Symposium Summary report within 4 weeks after the event.

Task 5: Make summaries of the presentations available online and in a report, so that AI/AN and CMS stakeholders can benefit from the data and findings.

Budget request: \$50,000 for one conference.



Objective 5d – CMS and TTAG annually will update and review its AI/AN research and evaluation plan to better track and evaluate CMS program services and policy impacts on AI/ANs and ITUs.

Task 1: CMS will work with the TTAG and its subcommittees, Tribal Epidemiology Centers, and the HHS Health Research Advisory Committee for AI/ANs (HRAC) to update the plan to identify additional data development and analysis work.

Task 2: Carry out additional data development and analysis activities that are of high impact or of a time sensitive nature.

Budget request: \$75,000 per year for objective 5d.

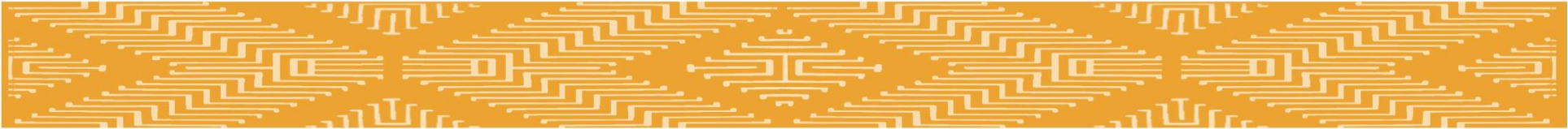


APPENDIX A: PLAN SUMMARY AND BUDGET

Goal 1: CMS engages in meaningful consultation with Tribes and work closely with the Tribal Technical Advisory Group (TTAG).						
Objectives & Tasks	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Objective 1a – On an annual basis, CMS will engage the TTAG to evaluate and revise the CMS Tribal Consultation Policy						
Task 1: Evaluate and revise existing CMS Tribal Consultation Policy, in collaboration with the TTAG and CMS Tribal Affairs Group (TAG), and provide an opportunity for Tribal consultation on the policy.	✓	✓	✓	✓	✓	✓
Task 2: Conduct an annual Tribal Consultation session.	75,000	75,000	75,000	75,000	75,000	75,000
Task 3: Written annual report documenting and evaluating consultation activities disseminated to partners in the first quarter of each fiscal year to assess both consultation processes and outcomes.	40,000	40,000	40,000	40,000	40,000	40,000
Objective 1b – In collaboration with the TTAG, CMS will develop mechanisms to involve tribes in states that have federal-facilitated exchanges and partnership exchanges to assure that I/T/U issues are addressed in the planning, policies, structure, and operations of those exchanges.						
Task 1: Beginning in 2012, health insurance exchanges workgroups that meet regularly to resolve issues.	✓	✓	✓	✓	✓	✓
Objective 1c – Each year, CMS will provide financial and administrative support to facilitate the ongoing activities of TTAG, and a sufficient budget to support TTAG activities included in the 2013-2018 Strategic Plan.						
Task 1: CMS will fully fund the Tribal Technical Advisory Group.	280,000	280,000	280,000	280,000	280,000	280,000



Task 2: CMS will actively seek American Indians and Alaska Natives to hire for key policy positions.	25,000	25,000	25,000	25,000	25,000	25,000
Task 3: The Tribal Affairs Group at CMS will report quarterly to TTAG activities and funding for implementation of this Strategic Plan	✓	✓	✓	✓	✓	✓
Task 4: CMS will retain at least 7 FTE personnel in the Tribal Affairs Group.	✓	✓	✓	✓	✓	✓
Objective 1d – CMS personnel with the authority to make binding decisions will regularly participate in TTAG meetings, the Annual DHHS Budget Consultation session, and DHHS regional tribal consultation meetings and listening sessions.						
Task 1: On an annual basis, the CMS Administrator, the CPC Director, the CMM Director, and the CMSO Director will participate in at least 3 face-to-face meetings with TTAG, along with other CMS officials.	✓	✓	✓	✓	✓	✓
Task 2: Key leadership from CMS Headquarters will attend annual DHHS regional tribal consultation meetings and listening sessions.	✓	✓	✓	✓	✓	✓
Objective 1e – By fiscal year 2013, CMS will develop a set of standard operating procedures that will be used by the agency to guide administrative decisions regarding Indian health policy						
Task 1: TTAG and the CMS Office of External Affairs will develop standard operating procedures that can be used by CMS to guide policy formation and Tribal consultation.	40,000	15,000	15,000	15,000	15,000	15,000
SUBTOTAL	460,000	435,000	435,000	435,000	435,000	435,000

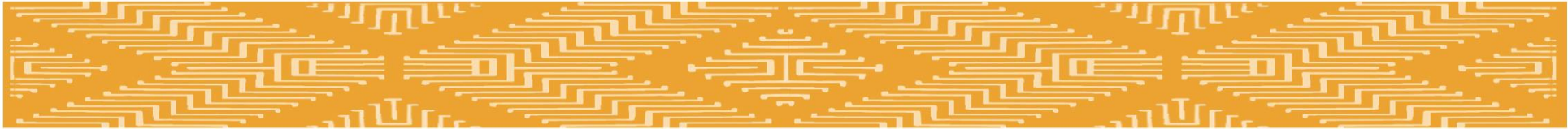


Goal 2: CMS enacts and implements policy through regulation, guidance, review and enforcement to align CMS programs to serve AI/AN by improving enrollment processes, assuring access to care, having efficient payment systems, and increasing the I/T/U capacity to deliver integrated, comprehensive programs.

Objective 2a – CMS will work with the TTAG to develop a global approach to funding enrollment assistance provided by the I/T/U and eligibility determinations for all CMS programs.

Task 1: Evaluate the number of States and Tribes using MAM to fund enrollment assistance and other approaches for assisting AI/AN who use I/T/U facilities to enroll in CMS programs through the health insurance exchange websites, and ways to simplifying applications and approvals for enrollment.	✓	✓	✓	✓	✓	✓
Task 2: Develop mechanisms for the I/T/U to receive Navigator or other funding from the Federally-facilitated Exchanges, the partnership exchanges and the state exchanges.	✓	✓	✓	✓	✓	✓
Task 3: Consider alternative sources of funding for the I/T/U to assist AI/AN to enroll in CMS funded programs, including Medicaid, Medicare and dual eligibles.	✓	✓	✓	✓	✓	✓
Task 4: Streamline systems to offer aggregate payment options and remove any barriers to Tribes and others paying premiums for enrollment in CMS programs.	✓	✓	✓	✓	✓	✓

Objective 2b – To maximize access to care and coordination of services for AI/ANs, CMS will work with the TTAG to develop processes to assure that the I/T/U can choose to be network providers for managed care organizations that deliver services with funding from Medicare, Medicaid, CHIP and Health Insurance Exchanges.



Task 1: Develop a prototype Indian Addendum that can be used with managed care provider contracts in all CMS programs.	✓	✓	✓	✓	✓	✓
Task 2: Adopt network adequacy standards to include I/T/U for managed care organizations funded through CMS programs.	✓	✓	✓	✓	✓	✓
Task 3: Review programs, policies, payment mechanisms and provide training and technical assistance to assure that the I/T/U can be the medical home for AI/AN who use their services.	✓	✓	✓	✓	✓	✓
Task 4: Assure that AI/AN who are enrolled in managed care organization through CMS programs can be referred to specialty care by I/T/U providers and that the laws and protections regarding deductibles and co-pays for AI/AN are followed.	✓	✓	✓	✓	✓	✓
Objective 2c – CMS will assure that the I/T/U is paid for all services provided that are covered by CMS programs for all AI/AN who are enrolled in Medicaid, Medicaid Expansion, Basic Health Plans, Medicare, and Health Insurance Exchanges.						
Task 1: CMS enforces the law that assures that the I/T/U is paid for off-plan services by managed care organizations with CMS funding.	✓	✓	✓	✓	✓	✓
Task 2: CMS will sponsor a conference to engage Tribal technical advisors and others on emerging payment approaches, analyze how those approaches may affect I/T/U, and share that information.	120,000	0	0	0	0	0
Task 3: All CMS programs will review their payment policies to assure that the I/T/U can be paid for telehealth services delivered to AI/AN.	✓	✓	✓	✓	✓	✓



Task 4: CMS will pay for Medicaid serves for AI/AN youth who are receiving treatment and/or enrolled in boarding schools in a different state from their parents (A/K/A Across State Borders).	✓	✓	✓	✓	✓	✓
Task 5: CMS will create a workgroup across all agencies and with the TTAG to develop criteria for I/T/U providers as distinct provider types for enrollment in Medicare and Medicaid.	✓	✓	✓	✓	✓	✓
Objective 2d – The Office for Dual Eligibles will work with a subcommittee of the TTAG to assure that there is integration of the Indian health system in new approaches for coordinating services and payments for people who are eligible for Medicaid and Medicare, and in some cases also eligible for services from the VA.						
Task 1: Workgroup on policy and data to implement AI/AN provisions of ARRA and ACA on eligibility and enrollment, federal data hub, and computer systems used by providers to flag AI/AN cost sharing protections, and performance metrics.	✓	✓	✓	✓	✓	✓
Objective 2e – CMS and the TTAG will work together to assure that AI/AN continue to receive needed services and the I/T/U continues to receive payment for those services In the context of States reforming their Medicaid programs, creating new types of waivers, choosing whether to implement Medicaid Expansion, and eliminating CHIP programs.						
Task 1: Information and technical assistance to Tribes and States to adopt principles and approaches used in Arizona Medicaid waiver to preserve services for AI/AN.	✓	✓	✓	✓	✓	✓
Task 2: Notify Tribes about State Medicaid reforms and consult with them.	120,000	0	0	0	0	0
Task 3: State Medicaid reform proposals approval contingent on continued services for AI/AN from I/T/U, and payment for those services.	✓	✓	✓	✓	✓	✓



Objective 2f – Offices within CMS that are responsible for enforcement and compliance will work with the TTAG to develop reasonable approaches for assuring that I/T/U adheres to laws and regulations.						
Task 1: Training on Indian health care delivery systems to CMS offices responsible for enforcement.	✓	✓	✓	✓	✓	✓
Task 2: Expedite consideration of recommendations regarding Safe Harbors submitted by Tribes and Tribal Organizations.	✓	✓	✓	✓	✓	✓
Task 3: Develop appropriate policies for compliance with tiered standards that consider the budgets, size, location and staffing of I/T/U facilities.	✓	✓	✓	✓	✓	✓
Task 4: Training, technical assistance, and funding for systems improvement to the I/T/U to comply with policies on disclosure and auditing.	✓	✓	✓	✓	✓	✓
Objective 2g – CMS will facilitate ARRA Section 5006 that authorizes American Indian Medicaid Managed Care Entities.						
Task 1: Sponsor a meeting on the creation of American Indian Medicaid Managed Care Entities under Section 5006 of ARRA.	0	150,000	150,000	0	0	0
Objective 2h – CMS will create internal processes and funding to facilitate partnerships with Tribes and Tribal organizations to work together on new policies and approaches to better align CMS and I/T/U programs.						
Task 1: Maintain funding for regulation review.	250,000	250,000	250,000	250,000	250,000	250,000
Task 2: Create better mechanisms to fund cooperative agreements with Tribes and Tribal Organizations.	✓	✓	✓	✓	✓	✓



Task 3: The CMS Office of Legislation will work with Tribes on mutually beneficial legislation, including revisions to ACA to clarify the definition of Indian and to address issues related to Medicaid Expansion.	✓	✓	✓	✓	✓	✓
Task 4: Move the CMS Tribal Affairs Group from the Office of Public Engagement to the Office of the Administrator.	✓	✓	✓	✓	✓	✓
SUBTOTAL	490,000	400,000	400,000	250,000	250,000	250,000
Goal 3: CMS Improves and expands the development and delivery of Long Term Services and Support (LTSS) throughout Indian communities.						
Objective 3a - Develop and maintain an interactive data base of current Long Term Services and Supports (LTSS) provided by the Indian Health Service (IHS), tribal health programs, and urban Indian health programs (I/T/U) with contact information for the providers. Develop tool kits to assist other health programs to evaluate options and develop similar programs. In addition, CMS working with IHS and the Administration for Community Living (ACL) in HHS will provide technical assistance to I/T/Us developing and taking advantage of these LTSS programs						
Task 1: Working with ACL and IHS, CMS will develop and maintain a website that will serve as an AI/AN LTSS portal.	125,000	100,000	100,000	0	0	0
Task 2: CMS will work with the TTAG, IHS and ACL to develop technical assistance materials for I/T/U.	✓	✓	✓	✓	✓	✓
Objective 3b - CMS will develop an AI/AN LTSS Delivery Plan and a LTSS Roadmap (formerly Toolkit) for Indian communities to provide information and guidance to I/T/Us wishing to research the possibilities of implementing LTSS programs in their communities.						
Task 1: Assist I/T/Us to assess their current LTSSs, develop an AI/AN LTSS Service Delivery Plan, and develop recommendations to engage States and CMS for financing LTSS in Indian communities.	✓	✓	✓	✓	✓	✓



Task 2: Develop a searchable web tool (LTSS Roadmap) as a part of the website development.	150,000	150,000	150,000	0	0	0
Objective 3c- Throughout the next five years, CMS and TTAG will work collaboratively to educate tribal leaders about long term care program planning and implementation, particularly regarding services that address the needs of elders, veterans, and persons with disabilities.						
Task 1: Annually review documents for I/T/U that describe principles and talking-points about the importance of LTSS, controlling costs, and improving quality.	✓	✓	✓	✓	✓	✓
Task 2: Quarterly development and dissemination of audience-specific educational materials for I/T/U leadership and staff that describe strategies to achieve increased access to LTSS in Indian communities.	100,000	100,000	100,000	100,000	100,000	100,000
Task 3: Annually identify existing meetings or conferences attended by I/T/U leaders and provide presentations there on LTSS services in Indian communities.	100,000	100,000	100,000	100,000	100,000	100,000
Task 4: Support annual AI/AN LTSS Conference.	200,000	200,000	200,000	0	0	0
Task 5: Fund a resource center to build capacity for LTSS for 15 Tribes.	300,000	1,500,000	1,500,000	0	0	0
SUBTOTAL	975,000	2,150,000	2,150,000	200,000	200,000	200,000



Goal 4: Every I/T/U facility is fully informed about CMS programs and every AI/AN knows about benefits to which they are entitled.

Objective 4a – Maintain effective communications between CMS and Tribes.

Task 1: Design and implement annual communications plan that facilitates a better understanding of CMS programs among I/T/U providers.	25,000	25,000	25,000	25,000	25,000	25,000
Task 2: CMS will use tribal organizations to share CMS information with Tribes via established communication channels.	150,000	150,000	150,000	150,000	150,000	150,000
Task 3: At the request of tribal organizations, CMS will participate in tribal meetings.	150,000	175,000	175,000	175,000	175,000	175,000
Task 4: CMS should contract with Area Indian Health Boards and other Tribal organizations to publicize CMS trainings and provide travel assistance for Tribal participation in regional trainings.	240,000	240,000	250,000	250,000	250,000	250,000

Objective 4b – Provide information, training and capacity building assistance to the I/T/U regarding CMS programs.

Task 1: Develop and implement annual training plan for I/T/U providers using appropriate Information Technology (IT) communication systems.	100,000	150,000	200,000	200,000	200,000	200,000
Task 2: Hold 20 training meetings per year to provide information about CMS programs to I/T/U employees.	750,000	750,000	750,000	750,000	750,000	750,000
Task 3: Develop, maintain and update web based manual of CMS policies and guidance specifically related to AI/AN and the I/T/U.	100,000	125,000	150,000	100,000	100,000	100,000



Task 4: All Tribes Calls related to Indian healthcare at least 6 times per year.	100,000	100,000	100,000	100,000	100,000	100,000
Task 5: Tribal-specific ICD-10 training in each of the 12 Areas of the IHS.	200,000	750,000	850,000	200,000	200,000	200,000
Objective 4c – Provide training and technical assistance for I/T/U facilities to maximize enrollment of eligible AI/AN in Medicaid, Medicaid Expansion, Medicare, CHIP and Health Insurance Exchanges.						
Task 1: Training and technical assistance to I/T/U and States to identify enrollment assistance funding for CMS programs.	100,000	100,000	100,000	100,000	100,000	100,000
Task 2: Training and technical assistance to I/T/U and States to increase use of electronic enrollment applications and determinations, and simplification of enrollment processes.	500,000	500,000	500,000	500,000	500,000	500,000
Task 3: Develop a simple and practical handout for enrollment assistance that explains the special provisions for AI/ANs in CMS programs.	125,000	200,000	125,000	0	0	0
Objective 4d – Provide materials and marketing designed to inform AI/AN consumers about CMS programs for which they may be eligible.						
Task 1: CMS will develop, design, produce and disseminate create materials that are culturally appropriate and effective in AI/AN communities, with an emphasis on the new Medicaid Expansion and Health Insurance Exchanges.	500,000	500,000	500,000	500,000	500,000	500,000
SUBTOTAL	3,040,000	3,765,000	3,875,000	3,050,000	3,050,000	3,050,000



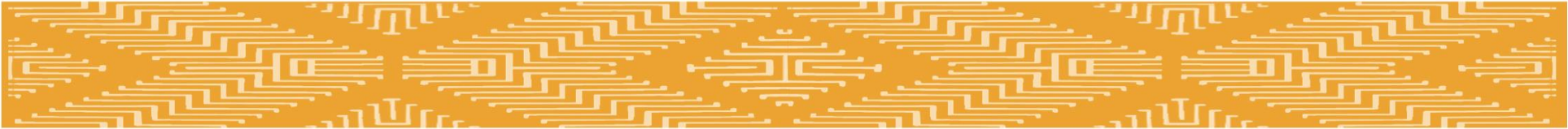
Goal 5: Develop and improve CMS data systems to evaluate and expand the capacity of CMS to serve American Indians and Alaska Natives.

Objective 5a – CMS will create data systems that identify AI/AN appropriately to assure that they are provided the benefits and protections under law and regulations (such as waiver of co-payments and deductibles) under Medicaid, Basic Health Plans, and Health Insurance Exchanges.

Task 1: Workgroup on policy and data to implement AI/AN provisions of ARRA and ACA on eligibility and enrollment, federal data hub, and computer systems used by providers to flag AI/AN cost sharing protections, and performance metrics.	✓	✓	✓	✓	✓	✓
Task 2: Twice a year CMS will hold a day of meetings at CMS for TTAG Data and Policy Committee members to exchange information with key CMS staff. Attendees will make recommendations to the CMS TTAG and suggest topics for follow-up. Presentations at AI/AN and CMS conferences, and in reports.	150,000	150,000	150,000	150,000	150,000	150,000

Objective 5b – Develop and improve data for the AI/AN populations within and outside of the IHS healthcare delivery system that can be used to evaluate CMS program enrollment, health care delivery, outcomes and payments across states and IHS Areas during the implementation of ACA, CHIPRA, ARRA and any subsequent health care policy changes.

Task 1: Establish baseline enrollment rates for AI/ANs and monitor changes.	✓	✓	✓	✓	✓	✓
Task 2: Establish baseline usage indicators for AI/ANs and monitor changes.	✓	✓	✓	✓	✓	✓
Task 3: Determine health outcomes for AI/ANs in CMS programs.	✓	✓	✓	✓	✓	✓
Task 4: Establish baseline CMS program payments for health care for AI/AN and monitor changes.	✓	✓	✓	✓	✓	✓
Task 5: Make evaluation data sets and findings available online, in presentations at AI/AN and CMS conferences, and in reports.	300,000	300,000	300,000	300,000	300,000	300,000



Objective 5c – Produce an AI/AN CMS Data Symposium on the impact of the implementation of ACA, CHIPRA ARRA and any subsequent health care policy changes on AI/AN and I/T/U providers.

Task 1: Sponsor AI/AN Data and Policy Conference.	✓	✓	✓	✓	✓	✓
Task 2: Conduct conference planning sessions with CMS staff, and secure the necessary personnel, materials, facilities and equipment to accomplish the tasks needed to plan, prepare and execute the Conference including making site arrangements for the event and travel arrangements for speakers.	✓	✓	✓	✓	✓	✓
Task 3: Provide brief descriptions of three research projects that could be carried out using AI/AN specific data.	✓	✓	✓	✓	✓	✓
Task 4: Technical writer for the symposium shall prepare Data Symposium Summary.	✓	✓	✓	✓	✓	✓
Task 5: Make summaries of the presentations available online, and in a report.	50,000	0	0	0	0	0

Objective 5d – CMS and TTAG annually will update and review its AI/AN research and evaluation plan to better track and evaluate CMS program services and policy impacts on AI/AN's and ITU's.

Task 1: CMS will work with the TTAG and its Sub Committees, Tribal Epidemiology Centers, and the DHHS Health Research Advisory Committee for AI/AN (HRAC) to update the plan to identify additional data development and analysis work.	✓	✓	✓	✓	✓	✓
Task 2: Carry out additional data development and analysis activities that are of high impact or of a time sensitive nature.	75,000	75,000	75,000	75,000	75,000	75,000
SUB-TOTAL	575,000	525,000	525,000	525,000	525,000	525,000
GOAL TOTALS	5,540,000	7,275,000	7,385,000	4,460,000	4,460,000	4,460,000





Appendix B: Legal Basis for Special CMS Provisions for American Indians and Alaska Natives

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I. Introduction

There is a special relationship between the United States and Indian Tribes that creates a trust responsibility toward Indian people regarding health care. The existence of this truly unique obligation supplies the legal justification and moral foundation for health policy making specific to American Indians and Alaska Natives (AI/ANs) – with the objectives of enhancing their access to health care and overcoming the chronic health status disparities of this segment of the American population.

It is beyond question that the obligation to carry out the trust responsibility to Indians applies to all agencies of the federal government – including the Centers for Medicare & Medicaid Services (CMS) – as evidenced by Presidential Executive Orders and Special Memoranda.⁶ Furthermore, with regard to health care for AI/ANs, federal law assigns comprehensive duties to the Secretary of the Department of Health and Human Services (HHS) in order to achieve the goals and objectives established by Congress for Indian health. The trust responsibility, and laws enacted pursuant thereto, provides ample authority for the Secretary – whether acting through the Indian Health Service (IHS), CMS, or other agency of HHS – to take pro-active efforts to achieve the Indian health objectives Congress has articulated.

⁵ The initial version of this Appendix D appeared in the first Strategic Plan submitted to CMS in 2005 by the CMS Tribal Technical Advisory Group. In that submission, the author acknowledged the Northwest Portland Area Indian Health Board (NPAIHB) and its member tribes for their generous support of the author's earlier work which provided foundation for that paper. That earlier paper, titled "The Federal Trust Responsibility: Justification for Indian-Specific Health Policy," was presented at the National Roundtable on the Indian Health System and Medicaid Reform sponsored by the NPAIHB at the Urban Institute on August 31, 2005. This Appendix D has been updated to reflect significant Indian-specific health policy legislative and administrative actions that have occurred since it was originally drafted. The authors would like to thank the United South and Eastern Tribes, Inc. for its generous support in updating this Appendix D.

⁶ See, e.g., Exec. Order No. 13175, 65 Fed. Reg. 67249 (Nov. 6, 2000) *reprinted in* 2000 U.S.C.C.A.N. at B77; White House Memorandum for Heads of Executive Departments and Agencies, Nov. 5, 2009; Dep't of Health and Human Services Tribal Consultation Policy (Dec. 14, 2010); Centers for Medicare and Medicaid Services Tribal Consultation Policy (Nov. 17, 2011); *Cramer v. United States*, 261 U.S. 219 (1923).



HHS and CMS both recognize this authority in their tribal consultation policy:

Since the formation of the Union, the United States (U.S.) has recognized Indian Tribes as sovereign nations. A unique government-to-government relationship exists between Indian Tribes and the Federal Government and this relationship is grounded in the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations, and executive orders that establish and define a trust relationship with Indian Tribes. This relationship is derived from the political and legal relationship that Indian Tribes have with the Federal Government and is not based upon race. This special relationship is affirmed in statutes and various Presidential Executive Orders ...⁷

While CMS often looks to the Social Security Act for authority, the historic and complex body of federal Indian law and case law applies throughout the federal government to all agencies, including CMS. The intent of this paper is to provide a brief summary of federal Indian law that is most relevant to current and future regulations and guidance regarding participation of Indians and the Indian health system in Medicare, Medicaid, Child Health Insurance Programs, and health insurance exchanges.

II. The United States has a Trust Responsibility to Indians

A. Origins of the trust responsibility to Indians

The federal trust responsibility to Indians, and the related power to exercise control over Indian affairs in aid of that responsibility, is rooted in the United States Constitution – most significantly the Indian Commerce Clause, the Treaty Clause, and the exercise of the Supremacy Clause.⁸ The Constitution contains no explicit language that defines the trust relationship. Rather, the parameters of the trust responsibility have evolved over time through judicial pronouncements, treaties, Acts of Congress, Executive Orders, regulations, and the ongoing course of dealings between the federal government and Indian tribal governments.

⁷ Dep't of Health and Human Services Tribal Consultation Policy (Dec. 14, 2010), at 1; Centers for Medicare and Medicaid Services Tribal Consultation Policy (Nov. 17, 2011), at 1.

⁸ *Morton v. Mancari*, 417 U.S. 535, 551-552 (1974) ("The plenary power of Congress to deal with the special problems of Indians is drawn both explicitly and implicitly from the Constitution itself."); *McClanahan v. Arizona State Tax Comm'n*, 411 U.S. 164, 172, n.7 (1973); see also TASK FORCE No. 9, VOL. 1, AMERICAN INDIAN POLICY REVIEW COMM'N 31 (1976) (explaining the origins of Constitutional power to regulate Indian affairs as flowing from Congress's treaty making powers, powers to regulate commerce with Indian tribes, and its authority to withhold appropriations); FELIX S. COHEN, HANDBOOK OF FEDERAL INDIAN LAW 418-423 (2005); Reid Payton Chambers, *Judicial Enforcement of the Federal Trust Responsibility to Indians*, 27 STAN. L. REV. 1213, 1215-1220 (1975).



The earliest formal dealings between the federal government and Indian Tribes were undertaken through treaty-making. From the United States' perspective, treaty objectives were essentially two-fold: cessation of hostilities to achieve and maintain public peace, and acquisition of land occupied by tribal members. Tribes doubtless had a peace-making motive as well, but in return for the vast tracts of land they relinquished to the more powerful federal government, Tribes also obtained the promise – expressed or implied – of support for the social, educational, and welfare needs of their people, including health care. These treaties/promises were the first expression of the federal government's obligation to Indian tribes.


The initial express recognition that a trust responsibility existed came from the courts. In the landmark case of *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831), Chief Justice John Marshall established the legal foundation for the trust responsibility by describing Indian Tribes as “domestic dependent nations” whose relationship with the United States “resembles that of a ward to his guardian.” *Id.* At 17. That theme – and the duty of the federal sovereign to Indian Tribes – carried forward some 50 years later when, in *United States v. Kagama*, 118 U.S. 375, 384 (1886), the Supreme Court acknowledged that Tribes are under the protection and care of the United States:

From their very weakness and helplessness, so largely due to the course of dealing of the federal government with them, and the treaties in which it has been promised, there arises the duty of protection, and with it the power [of protection].⁹

Through nearly two centuries of case law, the courts have extensively examined the parameters of the trust responsibility to Indians, frequently in the context of whether the federal government has the authority to perform an action and whether there are limitations on the exercise of Congressional power over Indian affairs. While Congress has plenary authority over Indian matters through the Constitution, the “guardian-ward” relationship articulated by Chief Justice Marshall requires that federal actions be beneficial, or at least not harmful, to Indian welfare. This is not to say, however, that the United States has always acted honorably toward Indians throughout its history.¹⁰ Nonetheless, the fact that our government has failed in some instances to act in an honorable manner

⁹ See also *Board of County Commissioners of Creek County v. Seber*, 318 U.S. 705, 715 (1943) (“Of necessity the United States assumed the duty of furnishing . . . protection [to Indian tribes] and with it the authority to do all that was required to perform that obligation . . .”).

¹⁰ An example is unilateral abrogation of Indian treaties by Congress. See, e.g., *Lone Wolf v. Hitchcock*, 187 U.S. 553 (1903).



toward Indians does not and should not absolve the more powerful sovereign from its responsibility to carry out its obligations honorably.


B. “Indian” as a *political* rather than a *racial* classification: Indian-specific lawmaking and the “rationally related” standard of review

In pursuit of its authority under the Constitution and the trust responsibility, Congress has enacted Indian-specific laws on a wide variety of topics¹¹ as well as included Indian-specific provisions in general laws to address Indian participation in federal programs.¹² In the landmark case of *Morton v. Mancari*, 417 U.S. 535 (1974), the Supreme Court set out the standard of review for such laws – the “rational basis” test. In *Mancari*, the Court reviewed an assertion by non-Indians that the application of Indian preference in employment at the Bureau of Indian Affairs (as ordered in the Indian Reorganization Act¹³) was racially discriminatory under the then-recently amended civil rights law which prohibited racial discrimination in most areas of federal employment.

¹¹ See, e.g., Indian Health Care Improvement Act, 25 U.S.C. § 1601, *et seq.*; Indian Self-Determination and Education Assistance Act, 25 U.S.C. §450, *et seq.*; Indian Education Act, 20 U.S.C. §7401, *et seq.*; Tribally Controlled Schools Act, 25 U.S.C. §2501, *et seq.*; Tribally Controlled College or University Assistance Act, 25 U.S.C. §1801, *et seq.*; Native American Housing Assistance and Self-Determination Act, 25 U.S.C. §4101, *et seq.*; Indian Child Welfare Act, 25 U.S.C. §1901, *et seq.*; Indian Child Protection and Family Violence Prevention Act, 25 U.S.C. §3201, *et seq.*; Indian Employment, Training, and Related Services Demonstration Act, 25 U.S.C. §3401, *et seq.*

¹² See, e.g., 42 U.S.C. §1395qq (eligibility of IHS/tribal facilities for Medicare payments); 42 U.S.C. §1396j (eligibility of IHS/tribal facilities for Medicaid payments); 42 U.S.C. §1397bb(b)(3)(D) (assurance of CHIP services to eligible low-income Indian children); Elementary and Secondary Education Act, as amended, 20 U.S.C. §6301, *et seq.* (funding set-asides throughout this law for the benefit of children enrolled in the Bureau of Indian Affairs school system); Impact Aid Program, 20 U.S.C. §7701, *et seq.* (federal aid to public school districts for Indian children living on Indian lands); Carl D. Perkins Vocational and Applied Technology Education Act, 20 U.S.C. §§2326 and 2327 (funding set-aside for Indian vocational education programs and tribal vocational Institutions); Higher Education Act, 20 U.S.C. §1059c (funding for tribally-controlled higher education institutions); Individuals with Disabilities Education Act, 20 U.S.C. §1411(c) (funding set-aside for Bureau of Indian Affairs schools); Head Start Act, 42 U.S.C. §9801, *et seq.* (includes funding allocation for Indian tribal programs and special criteria for program eligibility); Federal Highway Act, 23 U.S.C. §101, *et seq.* (1998, 2005, 2008 and 2012 amendments include funding set-asides for Indian reservation roads programs and direct development of regulations through Negotiated Rulemaking with tribes); American Recovery and Reinvestment Act of 2009, P.L. 111-5 (Feb. 17, 2009) (§5006 making amendments to the Social Security Act to provide various protections for Indians under Medicaid and CHIP, discussed below); Patient Protection and Affordable Care Act, P.L. 111-148 (Mar. 23, 2010) (various Indian specific provisions, discussed below).

¹³ 25 U.S.C. §461, *et seq.* The Indian hiring preference appears at 25 U.S.C. §472.




While the Supreme Court’s civil rights jurisprudence has generally applied strict scrutiny when reviewing classifications based on race, color, or national origin,¹⁴ in *Mancari* the Court determined that this test was not appropriate when reviewing an Indian employment preference law. Indeed, the Court declared that the practice under review was not even a “racial” preference. Rather, in view of the unique historic and political relationship between the United States and Indian Tribes, the Court characterized the preference law as *political* rather than *racial*, and said that “[a]s long as the special treatment [for Indians] can be tied rationally to the fulfillment of Congress’ unique obligation toward the Indians, such legislative judgments will not be disturbed.” *Id.* At 555. The Court found that hiring preferences in the federal government’s Indian service were intended “to further the Government’s trust obligation toward the Indian tribes,” to provide greater participation in their own self-government, and “to reduce the negative effect of having non-Indians administer matters that affect Indian tribal life” in agencies, such as the BIA, which administer federal programs for Indians. *Id.* At 541-542 (emphasis added).¹⁵

Once the link between special treatment for Indians as a political class and the federal government’s unique obligation to Indians is established, “ordinary rational basis scrutiny applies to Indian classifications just as it does to other non-suspect classifications under equal protection analysis.” *Narragansett Indian Tribe v. National Indian Gaming Comm’n.*, 158 F.3d 1335, 1340 (D.C. Cir. 1998).

The Indian hiring preference sanctioned by the Court in *Mancari* is only one of the many activities the Court has held are rationally related to the United States’ unique obligation toward Indians. The Court

¹⁴ The Supreme Court has interpreted Title VI to allow racial and ethnic classifications only if those classifications are permissible under the Equal Protection Clause. *Regents of Univ. of Cal. v. Bakke*, 438 U.S. 265, 287 (1978). In this regard, the Court has also stated that “all racial classifications, imposed by whatever federal, state, or local governmental actor, must be analyzed by a reviewing court under strict scrutiny. In other words, such classifications are constitutional only if they are narrowly tailored measures that further compelling governmental interests.” *Adarand Constructors, Inc. v. Peña*, 515 U.S. 200, 227 (1995).

¹⁵ Indian Preference provisions are not limited to the BIA, and have been applied in a variety of federal programs for the benefit of Indians. Section 7 of the Indian Self Determination Act, for example, establishes a broad federal policy of providing hiring, training, and contracting preferences for Indians in contracts or grants with Indian organizations across all federal agencies. 25 U.S.C. § 450e(b). Indian preference provisions are also found in other statutes. *See, e.g.*, 42 U.S.C. § 9839(h) (establishing an Indian hiring preference at American Indian Programs Branch of Head Start Bureau); 20 U.S.C. § 3423c(c) (establishing an Indian employment preference in the Office of Indian Education in the Department of Education). *See also Preston v. Heckler*, 734 F.2d 1359 (9th Cir. 1984) (Indian Preference Act requires Secretary of HHS to adopt standards for evaluating qualifications of Indians for employment in the Indian Health Service that are separate and independent from general civil service standards).



has upheld a number of other activities singling out Indians for special or preferential treatment, *e.g.*, the right of for-profit Indian businesses to be exempt from state taxation, *Moe v. Confederated Salish & Kootenai Tribes*, 425 U.S. 463, 479-80 (1976); fishing rights, *Washington v. Washington State Commercial Passenger Fishing Vessel Ass’n*, 443 U.S. 658, 673 n.20 (1979); and the authority to apply federal law instead of state law to Indians charged with on-reservation crimes, *United States v. Antelope*, 430 U.S. 641, 645-47 (1977). The Court in *Antelope* explained its decisions in the following way:

The decisions of this Court leave no doubt that federal legislation with respect to Indian tribes, although relating to Indians as such, *is not based upon impermissible racial classifications*. Quite the contrary, classifications singling out Indian tribes as subjects of legislation are expressly provided for in the Constitution and supported by the ensuing history of the Federal Government’s relations with Indians.

Antelope, 430 U.S. at 645 (emphasis added).

The courts continue to acknowledge the special political status of Indians and to uphold legislation singling out Indians on that basis. *See, e.g., Am. Fed’n of Gov’t Employees, AFL-CIO v. United States*, 330 F.3d 513, 522-23 (D.C. Cir. 2003) (finding outsourcing preference for Indian-owned firms was rationally related to the legitimate legislative purpose of promoting the economic development of federally recognized Tribes and their members); *United States v. Wilgus*, 638 F.3d 1274, 1287-88 (10th Cir. 2011) (upholding exception to the Bald Eagle Protection Act for Indian tribal members to possess eagle feathers).

III. Congress’s Recognition of the Federal Trust Responsibility in Health Laws

Since the early part of the 20th century, Congress has enacted a number of laws that authorize, direct, and fund the provision of health care services to Indian people.¹⁶ Here we focus on the most significant legislative enactments intended to ensure access of Indian people to federally-assisted health care programs and to enhance the viability of Indian Health Service and tribal programs that serve the Indian population.

A. The Indian Health Care Improvement Act

¹⁶ *See, e.g.,* Snyder Act, 25 U.S.C. § 13; Johnson-O’Malley Act, 25 U.S.C. § 452; Transfer Act, 42 U.S.C. § 2001, *et seq.* (transferred responsibility for Indian health to Public Health Service); annual appropriations to the Indian Health Service included in the Interior and Related Agencies Appropriations Acts.



The Indian Health Care Improvement Act (IHCIA)¹⁷ was originally enacted in 1976 as Public Law 94-437. It brought statutory order and direction to the delivery of federal health services to Indian people. Its legislative history catalogued the deplorable conditions of Indian health that demanded legislative attention: inadequate and under-staffed health facilities; improper or non-existent sanitation facilities; prevalence of disease; poor health status; inadequate funding;¹⁸ low enrollment of Indians in Medicare, Medicaid, and Social Security; serious shortage of health professionals, including Indian health professionals; and the need for health care for Indian people who had moved from reservations to urban areas. The legislation addressed each of these deficiencies through focused titles: Manpower; Health Services; Health Facilities (including sanitation facilities); Access to Medicare and Medicaid; Urban Indian Health; and a feasibility study for establishing an American Indian School of Medicine.¹⁹

The IHCIA has been periodically reauthorized and amended since 1976. In 2010, the law was comprehensively amended and authorized as a permanent law of the United States.²⁰ Throughout its history, the IHCIA has contained an unequivocal recognition of the United States' responsibility to improve the health of Indian people, to provide federal health services to this population, and to foster maximum Indian participation in health care program management. The 2010 amendments reiterated and reinforced these federal commitments through the following provisions:

Congressional Findings

The Congress finds the following:

- (1) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.
- (2) A major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and

¹⁷ 25 U.S.C. §1601, *et seq.* The Indian Health Care Improvement Act was amended and permanently reauthorized by Section 10221 of the Patient Protection and Affordable Care Act, P.L. 111-148 (Mar. 23, 2010).

¹⁸ The House Interior and Insular Affairs Committee noted that per capita spending on Indian health in 1976 was 25 percent less than the average American per capita amount. H.R. REP. No. 94-1026, pt. I, at 16 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652, 2655. According to the U.S. Commission on Civil Rights, IHS per capita spending for Indian medical care in 2003 was 62 percent lower than the U.S. per capita amount. U.S. Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System* (Sept. 2004), at 98.

¹⁹ The IHCIA was later amended to include formal establishment of the Indian Health Service as an agency of DHHS. Pub. L. No. 100-713 (1988). The IHS establishment is codified at 25 U.S.C. § 1661.

²⁰ Sec. 10221 of the Patient Protection and Affordable Care Act, P.L. 111-148 (Mar. 23, 2010).



opportunities that will eradicate the health disparities between Indians and the general population of the United States.

- (3) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.
- (4) Federal health services to Indians have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians.
- (5) Despite such services, the unmet health needs of American Indian people are severe and the health status of the Indians is far below that of the general population of the United States.²¹

Declaration of National Indian Health Policy

Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians –

- (1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;
- (2) to raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;
- (3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;
- (4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professions in each Service are raised to at least the level of that of the general population;
- (5) to require that all actions under this chapter shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this chapter and the national policy of Indian self-determination;
- (6) to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and
- (7) to provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.²²

It is important to note that these expressions of policy, obligation, and objectives apply to the federal government as a whole. The Act reposes responsibility for their implementation in the Secretary of Health and Human Services. While the Indian Health Service has first-line responsibility for administering the Indian health system, the Secretary of HHS remains the official with ultimate responsibility to see that programs are performed as directed and the objectives established by Congress are achieved. Thus, the obligation to exercise the trust responsibility for Indian health, to implement the expressed policies, and to achieve the stated goals extend to the Centers for Medicare & Medicaid Services, as an agency of HHS.

²¹ 25 U.S.C. §1601.

²² 25 U.S.C. §1602.



B. Statutory Authority for Participation in Medicare and Medicaid

In the 1976 IHCA, Congress amended the Social Security Act to extend to Indian health facilities the authority to collect Medicare and Medicaid reimbursements. Prior to these amendments, the IHS, as a federal agency, was not permitted to claim reimbursements from Medicare and Medicaid.

- Sec. 1880²³ made IHS hospitals (including those operated by Indian Tribes²⁴) eligible to collect Medicare reimbursement.
- Sec. 1911²⁵ made IHS and tribal facilities eligible to collect reimbursements from Medicaid
- An amendment to Sec. 1905(b)²⁶ applied a 100 percent federal medical assistance percentage (FMAP) to Medicaid services provided to an Indian by an IHS or tribally-operated facility.

Sections 1880 and 1911 were intended to bring additional revenue into the Indian health system in order to address the deplorable condition of Indian health facilities, many of which were in such a poor state they were unable to achieve accreditation. The application of a 100 percent FMAP to the Medicaid-covered services provided by these facilities was made in express recognition of the federal government's treaty obligations for Indian health. The Committee of jurisdiction observed that since the United States already had an obligation to pay for health services to Indians as *IHS beneficiaries*, it was appropriate for the U.S. to pay the full cost of their care as *Medicaid beneficiaries*.²⁷ This action is consistent with the status of AI/ANs as a *political* designation.

Through amendments to Sec. 1880 made in 2000, 2003 and 2010, IHS and tribal hospitals and clinics are authorized to collect reimbursements for all Medicare Part A and Part B services. As health care


²³ 42 U.S.C. §1395qq.

²⁴ Tribes and tribal organizations are authorized to operate IHS-funded hospitals and clinics through contracts and compacts issued pursuant to the Indian Self-Determination and Education Assistance Act, 25 U.S.C. § 450, *et seq.*

²⁵ 42 U.S.C. §1396j.

²⁶ 42 U.S.C. §1396d(b).

²⁷ H.R. REP. No. 94-1026, pt. III, at 21 (1976), as reprinted in 1976 U.S.C.C.A.N. 2782, 2796.



providers, IHS and tribal health programs are authorized to collect reimbursements under Medicare Parts C and D, as well.²⁸

C. Statutory Authority for Participation in CHIP

IHS and tribal health providers are authorized to collect payments when providing services to individuals enrolled in the Children’s Health Insurance Program (CHIP).²⁹ To assure that low-income Indian children who are CHIP-eligible are not overlooked, Congress, when creating the program in 1997, expressly required States to describe in their State plans the procedures they will use to assure access for these children.³⁰

D. Indian-Specific Provisions Designed to Ensure Indian Access to Medicaid, Medicare and CHIP


Since early 2009, Congress has added several significant provisions to Titles XIX and XXI of the Social Security Act that give voice to the federal government’s unique responsibility to Indian people and the need to remove barriers to their participation in Medicaid and CHIP, especially when AI/ANs eligible for those programs receive services from Indian health providers. We highlight these actions below.

- *Proof of Citizenship for Medicaid Enrollment.* In the Deficit Reduction Act of 2005 (DRA), Congress directed that on and after July 1, 2006, persons who apply to enroll or renew enrollment in Medicaid must provide documentary proof of identity and U.S. citizenship, and identified the types of documents that would be acceptable proof. Indian health advocates feared – correctly, as it turns out – that many AI/ANs would not possess sanctioned documentation of their status as U.S. citizens. Recognizing the barrier this presented for Indian access to Medicaid and CHIP, in 2009 Congress amended these requirements to designate documents issued by a federally-recognized Indian Tribe evidencing an individual’s membership, enrollment in, or affiliation with such Tribe as satisfactory evidence of U.S.

²⁸ In fact, Congress expressly authorized the Secretary of HHS to issue standards to assure access by pharmacies operated by the IHS, tribes and urban Indian organizations to the Medicare Part D prescription drug benefit (42 U.S.C. §1395w-104(b)(1)(C)(iv)), and required the Secretary to establish procedures (including authority to waive requirements) to assure participation by these pharmacies in the transitional assistance feature of the temporary discount drug program. 42 U.S.C. §1395w-141(g)(5)(B). Congress added language in the Affordable Care Act to allow Indian patients to qualify for the catastrophic coverage phase of the Part D program. 42 U.S.C. §1395w-102(b)(4)(C).

²⁹ 42 U.S.C. §2105(c)(6)(B); *see also* 25 U.S.C. §1647a.

³⁰ 42 U.S.C. §2103(a)(3)(D).



citizenship.³¹ Significantly, Congress gave tribal documentation “tier I” status – the same as a U.S. passport. Individuals presenting tribal affiliation documentation would not be required to present any additional identity documentation.

This legislative action recognizes not only the historic reality that Indian people were the original occupants of the North American continent, it also implements in the clearest possible way the policy of maintaining a government-to-government relationship with Indian Tribes. It also demonstrates respect for the sovereignty of Tribes both to determine tribal membership and to issue legal documents. As a practical matter, amending the law to order acceptance of tribal documentation underscores Congress’s recognition of its continued responsibility to enact Indian-specific legislation when needed to assure full access to federal programs.

- *Medicaid Premium and Cost-Sharing Protections.* Pursuant to an amendment to Medicaid made in 2009, States are prohibited from imposing any premium or cost-sharing on an Indian for a covered service provided by the IHS, a health program operated by an Indian Tribe, Tribal Organization or urban Indian organization, or through referral under contract health services.³²
- *Disregard of Certain Indian Property from Resources for Medicaid and CHIP Eligibility.* In 2009, Congress amended the Medicaid and CHIP laws to exempt from the resources calculation certain enumerated types of Indian property. Primarily, the excluded property is of a type that flows to an individual Indian by virtue of his/her membership in a Tribe.³³
- *Medicaid Estate Recovery Protections.* In an express endorsement of a provision in the CMS State Medicaid Manual, in 2009 Congress statutorily exempted certain Indian-related income, resources and property held by a deceased Indian from the Medicaid estate recovery

³¹ 42 U.S.C. §1396b(x)(3)(B), as added by Sec. 211 of the Children’s Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) (Feb. 4, 2009).

³² 42 U.S.C. §§1396o(j) and 1396o-1(b)(3)(vii), as added by Sec. 5006(a) of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) (Feb. 17, 2009). In recognition of the trust responsibility, Indian children have been exempt from cost-sharing in the CHIP program pursuant to regulation at 42 C.F.R. §457.535.

³³ 42 U.S.C. §§1396a(ff) and 1397gg(e)(1)(H), as added by Sec. 5006(b) of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) (Feb. 17, 2009).



requirement.³⁴ The objective of the Manual and statutory protection was to remove a disincentive to enrollment for Indian people eligible for Medicaid.

- *Special Indian-specific Rules for Medicaid Managed Care.* In 2009, Congress removed several barriers to full and fair participation of Indian people and Indian health providers in Medicaid programs operated through managed care entities. This gave an Indian Medicaid enrollee the option to select an Indian health program as his/her primary care provider, and directed that Indian health providers (IHS, tribal, and urban Indian organization programs) be paid at a rate not less than that of the managed care entity's network provider.³⁵ These changes were needed to overcome the reluctance of managed care entities to admit Indian health providers to their networks and to reimburse them for services provided to Indian Medicaid enrollees.
- *Authority for Tribal Medicaid Administrative Match.* Federal funds may not be used to meet State matching requirements, except as authorized by Federal law. In 2005, CMS issued a State Medicaid Director letter that permits Indian Tribes and Tribal Organizations to certify funds received under the Indian Self-Determination and Education Assistance Act as public expenditures to be used as the non-Federal share of expenditures to fulfill State matching requirements for administrative claiming activities under the Medicaid program. These activities include, among other things, outreach and application assistance for Medicaid enrollment and activities that ensure appropriate utilization of Medicaid services by Medicaid beneficiaries.

E. Solicitation of Input from Indian Health Programs.

In recognition of the need to assure that impacts on the unique Indian health system by proposed changes in Medicare, Medicaid, and CHIP are fully evaluated, Congress placed in the Social Security Act a requirement for prior notice to and solicitation of input from IHS, tribal health programs, and urban

³⁴ 42 U.S.C. §1396p(b)(3)(B), as added by Sec. 5006(c) of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) (Feb. 17, 2009).

³⁵ 42 U.S.C. §1396u-2(h), as added by Sec. 5006(d) of the American Recovery and Reinvestment Act (P.L. 111-5) (Feb. 17, 2009).



Indian organizations. On the federal level, this requirement is to be carried out by CMS through maintenance of the Tribal Technical Advisory Group originally chartered by the agency in 2003.³⁶

States are required to solicit advice from IHS and tribal health programs and urban Indian organizations within their borders prior to submission of any state plan amendments, waiver requests, and demonstration projects to CMS.³⁷

F. Cap on Rates Charged for Contract Health Services.

Modeling on the Medicare Provider Agreement provision that caps the amount a hospital can charge for services purchased by the Department of Veterans Affairs, in 2003 Congress enacted a similar limitation on the amount a Medicare participating hospital may charge for services purchased by Indian health programs operated by the IHS, Tribes, and Tribal Organizations, and urban Indian organizations (I/T/Us). As a condition for participation in Medicare, such hospitals must accept patients referred by I/T/Us in accordance with the admission practices, payment methodology, and payment rates set forth in Secretarial regulations, and may accept no more than the payment rates set by the Secretary.³⁸ This statutory rate cap is often referred to by the shorthand “Medicare-like rates.”

In regulations issued by IHS and CMS in 2007, the maximum amount a Medicare hospital is permitted to accept for a service purchased by an I/T/U is the applicable Medicare rate.³⁹

These statutory and regulatory actions are intended to enable I/T/Us to achieve greater economies for the services they must purchase for their Indian patients with funds appropriated for contract health services.

³⁶ 42 U.S.C. §1320b-24, as added by Sec. 5006(e)(1) of the American Recovery and Reinvestment Act (P.L. 111-5) (Feb. 17, 2009). The maintenance of the Tribal Technical Advisory Group does not substitute for government-to-government consultation with tribes.

³⁷ 42 U.S.C. §§1396a(a)(73) and 1397gg(e)(1)(C), as added by Sec. 5006(e)(2) of the American Recovery and Reinvestment Act (P.L. 111-5) (Feb. 17, 2009).

³⁸ 42 U.S.C. §1395cc(a)(1)(U), as added by the Medicare Modernization Act of 2003 (P.L. 108-173).

³⁹ 72 Fed. Reg. 30706 (June 4, 2007), adding Subpt. D to 42 C.F.R. Part 136, and adding §489.29 to 42 C.F.R. Part 489. These regulations became effective on July 5, 2007.




G. Indian-Specific Provisions Designed to Ensure Indian Access to the Health Insurance Exchanges

The Patient Protection and Affordable Care Act (ACA) was enacted by Congress in 2010 in order to reform the health insurance market and make health insurance more accessible and affordable for all Americans. It imposes a responsibility on most Americans to acquire or maintain health insurance coverage, and contains a number of provisions intended to strengthen health insurance consumer protections and enhance the health care workforce. Congress included a number of provisions designed to ensure that Indians could take advantage of the new reforms. We highlight several of these below.

- *Exemption from Penalty for Failure to Comply with the Individual Mandate.* Although Congress designed the law to make nearly all Americans responsible for acquiring or maintaining acceptable levels of health insurance coverage, Congress specifically exempted members of Indian Tribes from the tax penalty for failure to obtain acceptable coverage.⁴⁰ This provision is based on the theory that the United States is responsible for providing health care to Indians, but it has failed to supply an acceptable package of benefits through the Indian Health Service. Having failed in that responsibility, it would violate the trust responsibility to require Indians to pay for non-IHS coverage or be assessed a tax penalty for failing to do so.
- *Cost-Sharing Protections for Indians Enrolled in a Health Insurance Exchange Plan.* The Affordable Care Act prohibits assessment of any cost-sharing for any service provided by an Indian health provider to an AI/AN enrolled in an Exchange plan. Furthermore, no cost sharing may be assessed by non-Indian health providers to an AI/AN enrolled in such a plan if the individual receives services through an Indian health provider or through contract health services. Indians with income below 300 percent of the Federal Poverty Level do not have cost sharing in the private sector even if they do not have a referral from an Indian health provider. The Secretary of HHS is responsible for paying the Exchange plan the additional actuarial cost that results from these cost-sharing protections.⁴¹
- *Special enrollment periods for AI/AN.* The ACA provides special enrollment periods for AI/ANs for health insurance exchanges. This is another measure to provide access to this important source of funding for the I/T/U.

⁴⁰ 26 U.S.C. §5000A(e)(3).

⁴¹ 42 U.S.C. §18071(d).



These provisions are designed to reduce the costs for AI/ANs to access the Exchange plans and to provide incentives for them to do so, as well as to increase the likelihood that I/T/Us will receive payments from health insurance exchange plans for services they provide to AI/Ans.

IV. Executive Branch Recognition of the Federal Trust Responsibility in Administering Federal Health Programs

A. Executive Branch Administration of the Trust Responsibility

The Executive Branch is responsible for carrying out the federal trust responsibility to provide health care to Indians. The federal government’s general trust duty to provide social services and its duty as a trustee to protect and manage Indian trust property are different types of duties and thus are treated differently by the courts.⁴² Courts have generally been reluctant to impose liability for the federal government’s failure to provide social services under the general trust relationship.⁴³ One notable exception is the case of *Morton v. Ruiz*⁴⁴ where the Supreme Court said the Bureau of Indian Affairs erred in refusing to provide welfare benefits to unemployed Indians who lived off, but near, their reservation. The Court reiterated that the “overriding duty of our Federal Government [is] to deal fairly with Indians wherever located”, and that BIA’s failure to publish eligibility criteria through Administrative Procedure Act regulations was not consistent with the “distinctive obligation of trust incumbent upon the Government in its dealings” with Indians.⁴⁵

The IHCIA policy statements quoted above expressly recognize a trust responsibility to maintain and improve the health of Indians, and establish a national policy to assure the highest possible health status to Indians, as well as to provide all resources necessary to effect that policy. While currently there may be no available mechanism to enforce these policies judicially, this does not make them meaningless. They establish the goals, which the Executive Branch – particularly the Department of Health and Human Services – must strive to achieve as it implements federal law. In fact, they justify – indeed, require – the Executive Branch to be proactive and use its resources “to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect

⁴² *Seminole Nation v. United States*, 316 U.S. 286, 297 (1942).

⁴³ See, e.g., *Gila River Pima-Maricopa Indian Community v. U.S.*, 427 F.2d 1194 (Ct.Cl. 1970), cert. denied. 400 U.S. 819 (1970).

⁴⁴ 415 U.S. 199 (1974).

⁴⁵ *Id.* at 236. See also Chambers, note 2, *supra*, at 1245-46 (arguing that courts should apply the trust responsibility as a “fairness doctrine” in suits against the United States for breach of a duty to provide social services).



that policy.” 25 U.S.C. §1602(1). The Executive Branch has a dual duty – to carry out the policy established by Congress in federal law, and to perform the United States’ trust responsibility to Indians in accord with the Congressionally-established standard.

Indian people take the United States at its word when reading the policy statement in the IHCIA, and have a right to expect its trustee to achieve the goal of assuring them the highest possible health status. As stated by Justice Black in his lament over the U.S. breaking faith with Indians, “Great nations, like great men, should keep their word.”⁴⁶

B. CMS Administration of the Trust Responsibility

As part of DHHS, and as an agency required to implement statutory provisions intended to benefit Indian health, CMS should affirmatively advance policy objectives as set out by Congress in the IHCIA when making Indian-related decisions in the Medicare and Medicaid programs. The trust responsibility and the federal laws enacted to carry it out not only permit CMS to treat AI/ANs served by the Indian health system as unique Medicare and Medicaid consumers entitled to special treatment, they require it.


CMS shares the responsibility to carry out the policy goals established by Congress in the IHCIA. Both the HHS and CMS tribal consultation policies recognize “the unique government to government” relationship between the United States and Tribes, as well as the trust responsibility “defined and established” by “the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations, and executive orders.”⁴⁷ One manifestation of this trust responsibility is CMS’s recognition that “CMS and Indian Tribes share the goals of eliminating health disparities for American Indians and Alaska Natives (AI/AN) and of ensuring that access to Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and Exchanges is maximized.”⁴⁸ Through its consultation policy, CMS has committed to consulting with Indian Tribes when developing policy that may affect Indians.

CMS has exercised its authority to administer federal health care programs and interpret the statutes within its jurisdiction in a manner that assures access by Indian people and participation by the unique Indian health delivery system. In recent decades, CMS (previously HCFA) has taken steps to carry out

⁴⁶ *Federal Power Comm’n v. Tuscarora Indian Nation*, 362 U.S. 99, 142 (1960) (Black, J., dissenting),

⁴⁷ Centers for Medicare & Medicaid Services Tribal Consultation Policy (Nov. 17, 2011), at 1; U.S. Dep’t of Health and Human Services Tribal Consultation Policy (Dec. 14, 2010), at 1.

⁴⁸ Centers for Medicare & Medicaid Services Tribal Consultation Policy (Nov. 17, 2011), at 2.



the trust responsibility to Indians in its administration of the Medicare, Medicaid, and CHIP programs. Each was a rational exercise of the agency’s authority and fully justified by the United States’ special obligations to Indian Tribes.

A summary of these actions follows:

- *Authority for Tribal Facilities to Bill Medicaid at the Same Rate as IHS Facilities.* In 1996, through a Memorandum of Agreement with IHS, HCFA re-interpreted the term “facility of the Indian Health Service” in Section 1911 (Medicaid) to allow a tribally-owned facility operated under an ISDEAA agreement to elect designation as a “facility of the Indian Health Service.” Previously, HCFA had interpreted the term “facility of the Indian Health Service” to include only facilities actually owned or leased by IHS. The MOA enabled these tribally-owned facilities to bill Medicaid at the annually-established Medicaid billing rates for IHS facilities and applied the 100 percent FMAP to Medicaid services provided by such facilities.
- *Exemption of IHS and Tribal Clinics from the Outpatient Prospective Payment System.* In 2002, the Director of the Center for Medicare agreed to continue the exemption of IHS and tribal clinics from the Outpatient Prospective Payment System.
- *CMS has Broadly Defined the Hospital Services that are Subject to the Medicare-like Rates Cap.* In 2007, CMS issued regulations implementing Section 506 of the Medicare Modernization Act to require all Medicare-participating hospitals to accept Medicare-like rates when providing services to I/T/U beneficiaries. The final regulations broadly defined hospital and critical access hospital services subject to the rule to include inpatient, outpatient, skilled nursing facilities, and any other service or component of a hospital. 42 C.F.R. §136.30; 42 C.F.R. §489.29.
- *IHS and Tribal Facility Participation in Medicaid.* The 1996 IHS/HCFA MOA incorporated the regulatory policy that states must accept as Medicaid providers IHS facilities that meet state requirements, but these facilities are not required to obtain a state license. 42 C.F.R. §431.110. Thus, it applied this regulatory policy to tribally-owned facilities. Congress converted this policy into law for all federally-funded health programs serving AI/AN in the 2010 amendments to the Indian Health Care Improvement Act.⁴⁹

⁴⁹ 25 U.S.C. §1647a.




- *Cost-Sharing Protections for Indian Children in CHIP.* In 1999, HCFA issued guidance, followed by a proposed rule, that prohibits states from imposing any cost-sharing on AI/AN children under CHIP, citing the unique federal relationship with Indian Tribes. This rule was subsequently promulgated in final form. 42 C.F.R. §457.535. This HCFA regulation reflects the agency's interpretation of how best to carry out the statutory provision requiring states to demonstrate how they will assure CHIP access for eligible Indian children. 42 U.S.C. §1397bb(b)(3)(D). In 2000, HCFA announced that the policy prohibiting cost sharing for Indian children under CHIP would be extended to Section 1115 Medicaid demonstration projects and stated the agency would no longer approve Section 1115 projects that impose such cost-sharing. 66 Fed. Reg. 2490, 2526 (Jan. 11, 2001).
- *State-Tribal Consultation on Medicaid Programs.* In 2001, CMS issued a policy statement that requires states to consult with Tribes within their borders on Medicaid waiver proposals and waiver renewals before submitting them to CMS.⁵⁰ Congress subsequently made this consultation requirement statutory, adding State Plan Amendments and demonstration projects as requisite subjects of tribal consultation.⁵¹ CMS informed the States of this consultation requirement on several occasions and codified the 2001 policy statement.⁵² In May of 2012, CMS announced that it would not accept the waiver applications submitted by New Mexico and Kansas until they met the tribal consultation requirements.
- *CMS Tribal Technical Advisory Group.* In 2003, CMS chartered a Tribal Technical Advisory Group comprised of tribal officials and tribal employees to advise the agency on Medicare, Medicaid, and CHIP issues that impact Indian health programs. CMS's foresight was met with approval by Congress, which granted the TTAG explicit statutory status in 2009 and added representatives of the IHS and urban Indian organizations to the TTAG's membership. 42 U.S.C. §1320b-24.
- *Indian Health Addendum Required for Medicare Part D Pharmacy Contracts.* When implementing the Medicare Part D drug benefit, CMS recognized that special terms and conditions in pharmacy contracts would be needed to assure that IHS, tribal, and urban Indian

⁵⁰ Letter from Health Care Fin. Admin. To State Medicaid Directors (July 17, 2001)
<http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd071701.pdf>.

⁵¹ 42 U.S.C. §§1396a(a)(73) and 1397gg(e)(1)(C), as added by Sec. 5006(e)(2) of the American Recovery and Reinvestment Act (P.L. 111-5) (Feb. 17, 2009).

⁵² CMS SMD #09-003 (June 17, 2009); CMS SMDL #10-001 (Jan. 22, 2010); 77 Fed. Reg. 11678 (Feb. 27, 2012).



organization pharmacies would be able to participate in the Part D program. The agency requires Part D plans to include the CMS-approved text of an Indian Health addendum in contracts offered to those pharmacies. 42 C.F.R. §423.120(a)(6). The addendum addresses several aspects of federal law and regulations applicable to those pharmacies, such as Federal Tort Claims Act coverage (obviating the need for privately-purchased professional liability insurance).⁵³

- *Approval of Indian-specific State Medicaid Plan Provision.* In April of 2012, CMS approved an Arizona Medicaid waiver request through which several optional Medicaid services can continue to be covered at IHS and tribal facilities, although they are otherwise discontinued from coverage in the State's plan. When these services are provided to Indian patients at IHS and tribal facilities, the 100 percent FMAP continues to apply. This action is a significant acknowledgement by CMS that it has the authority and the obligation to carry out its trust responsibility for Indian health.

Carrying out the trust responsibility to Indians in these and other ways coincides with and compliments CMS's stated program objectives.


V. The Unique Nature of the Indian Health System

The IHS-funded system for providing health services to AI/ANs is one-of-a kind; it is unlike any other mainstream health delivery system. In fact, the federal government created and designed the system in use today for the specific purpose of serving Indian people in the communities in which they live. Overall, the Indian health programs have a community-based approach and seek to provide culturally-appropriate services. As demonstrated in this Plan, the IHS system was created for Indian people as a political class, not as a racial group. These circumstances require unique rules and policies from CMS to enable IHS-funded programs to fully access Medicare, Medicaid, and CHIP and to achieve the agency's health disparities elimination objective.

We outline below some of the unique circumstances of this health system and of Indian Tribes that have been established or recognized by federal law and regulations:

- *Limited service population.* The IHS health care system is not open to the public. It is established to serve AI/AN beneficiaries who fall within the eligibility criteria established by the

⁵³ The text of the Addendum is included in the Medicare program's solicitation for applications for new cost plan sponsors. See, e.g., "Medicare Prescription Drug Benefit, Solicitation for Applications for New Cost Plan Sponsors, 2012 Contract Year," at 131.




IHS. See 42 C.F.R. §136.12.⁵⁴ The IHS estimates the service population served by IHS and tribally-operated programs in more than 30 states is approximately 2.1 million AI/Ans.

- *No cost assessed to patients.* IHS serves AI/AN beneficiaries without cost. For several years, Congress reinforced this policy with language in the annual IHS appropriations act that prohibited the agency to charge for services without Congressional consent.⁵⁵ IHS services at no cost to the Indian patient remains IHS policy today. Some members of Congress have described the IHS as a pre-paid health plan – pre-paid with land ceded by Tribes to the U.S. government.
- *Indian preference in employment.* Indian preference in hiring applies to the Indian Health Service. 42 C.F.R. §136.41-.43.⁵⁶ Such preference also applies to tribally-operated programs through the requirement that, to the greatest extent feasible, preference for training and employment must be given to Indians in connection with administration of any contract or grant authorized by any federal law to Indian organizations or for the benefit of Indians. 25 U.S.C. §450e(b).
- *Only Tribes have rights under ISDEAA.* Indian Tribes (and Tribal Organizations sanctioned by one/more Tribes) – and only those entities – can elect to directly operate an IHS-funded program through a contract or compact from the Indian Health Service issued pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA). 25 U.S.C. §450 *et seq.* The tribal operator receives the program funds the IHS would have used and additional funding for administrative costs. A tribal operator directly hires its staff and has the authority to re-design the program(s) it offers.
- *Federal Tort Claims Act coverage.* Pursuant to federal law, tribal health programs and their employees are covered by the Federal Tort Claims Act (FTCA). 25 U.S.C. §450f, note. For this

⁵⁴ Under certain circumstances non-Indians connected with an Indian beneficiary (such as minor children and spouses) can receive services as beneficiaries. Other non-Indians may receive services in carefully defined circumstances, but are liable for payment. See 25 U.S.C. §1680c.

⁵⁵ See, e.g., Pub. L. No. 104-134, 110 Stat. 1321-190 (April 26, 1996).

⁵⁶ See also *Preston v. Heckler*, 734 F.2d 1359 (9th Cir. 1984) (upholding the Indian Health Service's Indian employment preference).



reason, it is often unnecessary for Tribes to purchase liability insurance for the health services they operate with federal funding.

- *Use of HHS personnel.* To help staff their programs, Tribes and Tribal Organizations are authorized by law to utilize employees of HHS under Intergovernmental Personnel Act assignments and commissioned officers of HHS under Memoranda of Agreement. 25 U.S.C. §450i.
- *Creation of specific health care providers.* Federal law has created health care delivery providers found only in the Indian health care system. See Community Health Representative Program, 25 U.S.C. §1616; Community Health Aide Program (CHAP) for Alaska, 25 U.S.C. §1616. The Alaska Medicaid Plan reimburses Indian health programs for covered services provided by CHAPs in Alaska. Through a 2010 amendment to the IHCA, the Secretary is authorized to implement a CHAP program for Tribes in the lower 48 states.
- *IHS as payer of last resort.* A longstanding IHS regulation makes IHS programs the payer of last resort for eligible Indian beneficiaries, notwithstanding any state or local law to the contrary. 42 C.F.R. §136.61. Congress has made this payer of last resort status a statutory requirement for IHS, tribal, and urban Indian organization programs.⁵⁷
- *IHS-specific Medicare and Medicaid reimbursement rates.* On an annual basis, the IHS (in consultation with CMS) establishes the rates at which Medicare outpatient and Medicaid inpatient and outpatient services provided to eligible Indians shall be reimbursed to IHS facilities. See, e.g., 77 Fed. Reg. 33470 (June 6, 2012). This is an all-inclusive encounter rate which is unique to Indian health care. Tribal clinics may instead elect to bill for services as a Federally Qualified Health Center (FQHC).
- *100 Percent Federal Medical Assistance Percentage.* The cost of Medicaid covered services provided to AI/ANs in IHS and tribal facilities are reimbursed to the States at 100 percent FMAP in recognition that the responsibility for Indian health care is a federal obligation. Sec. 1905(b) of SSA; 42 U.S.C. §1396d(b).

⁵⁷ 25 U.S.C. §1623(b), as added by Sec. 2901(b) of the Affordable Care Act (P.L. 111-148) (Mar. 23, 2010).



- *No U.S. right of recovery from Tribes.* If an Indian Tribe (or a Tribal Organization sanctioned by one/more Tribes) has a self-insured health plan for its employees, the United States is prohibited by law from recovering from that plan the cost of services provided unless the sponsoring Tribe/Tribal Organization expressly authorizes such recovery. 25 U.S.C. §1621e(f).
- *Indian Tribes are governments.* Upon achieving federal recognition, an Indian Tribe is acknowledged to be and is treated as a *government* by the United States. The U.S. deals with Indian Tribes on a government-to-government basis that is recognized in Executive Orders and consultation policies adopted by federal agencies.⁵⁸ Indian Tribes determine their own governmental structure. They are not required to follow the U.S. model of separate legislative, executive, and judicial branches.
- *State law does not apply.* By virtue of the Supremacy Clause, state laws generally do not apply to the IHS system.⁵⁹ The Supreme Court has recognized that Indian tribal governments are not subject to state laws, including tax laws, unless those laws are made expressly applicable by federal law. *See, e.g., McClanahan v. Arizona State Tax Comm'n*, 411 U.S. 1641 (1973). Indian tribal governments are not political subdivisions of states. Tribal facilities and their employees may not be required to have state licensure to perform their duties.
- *Federal trust responsibility.* The United States has a trust responsibility to Indian Tribes (described above).
- *Tribal sovereign immunity.* Indian tribal governments enjoy sovereign immunity except vis-à-vis the United States government, the superior sovereign. *See, e.g., United States v. United States Fidelity & Guaranty Co.*, 309 U.S. 506 (1940).

⁵⁸ *See, e.g.,* Exec. Order No. 13175, "Consultation and Coordination with Indian Tribal Governments (Nov. 9, 2000) (issued by President Clinton and subsequently endorsed by Presidents George W. Bush and Barack Obama); White House Memorandum for Heads of Executive Departments and Agencies, Nov. 5, 2009 (President Obama endorsement); Dep't of Health and Human Services Tribal Consultation Policy (Dec. 14, 2010); Centers for Medicare and Medicaid Services Tribal Consultation Policy (Nov. 17, 2011).

⁵⁹ For example, Section 408 of the IHCA provides that an entity operated by IHS, an Indian tribe, tribal organization or urban Indian organization that meets state requirements for licensure must be accepted as a provider but is not required to obtain a state license. 25 U.S.C. §1647a.



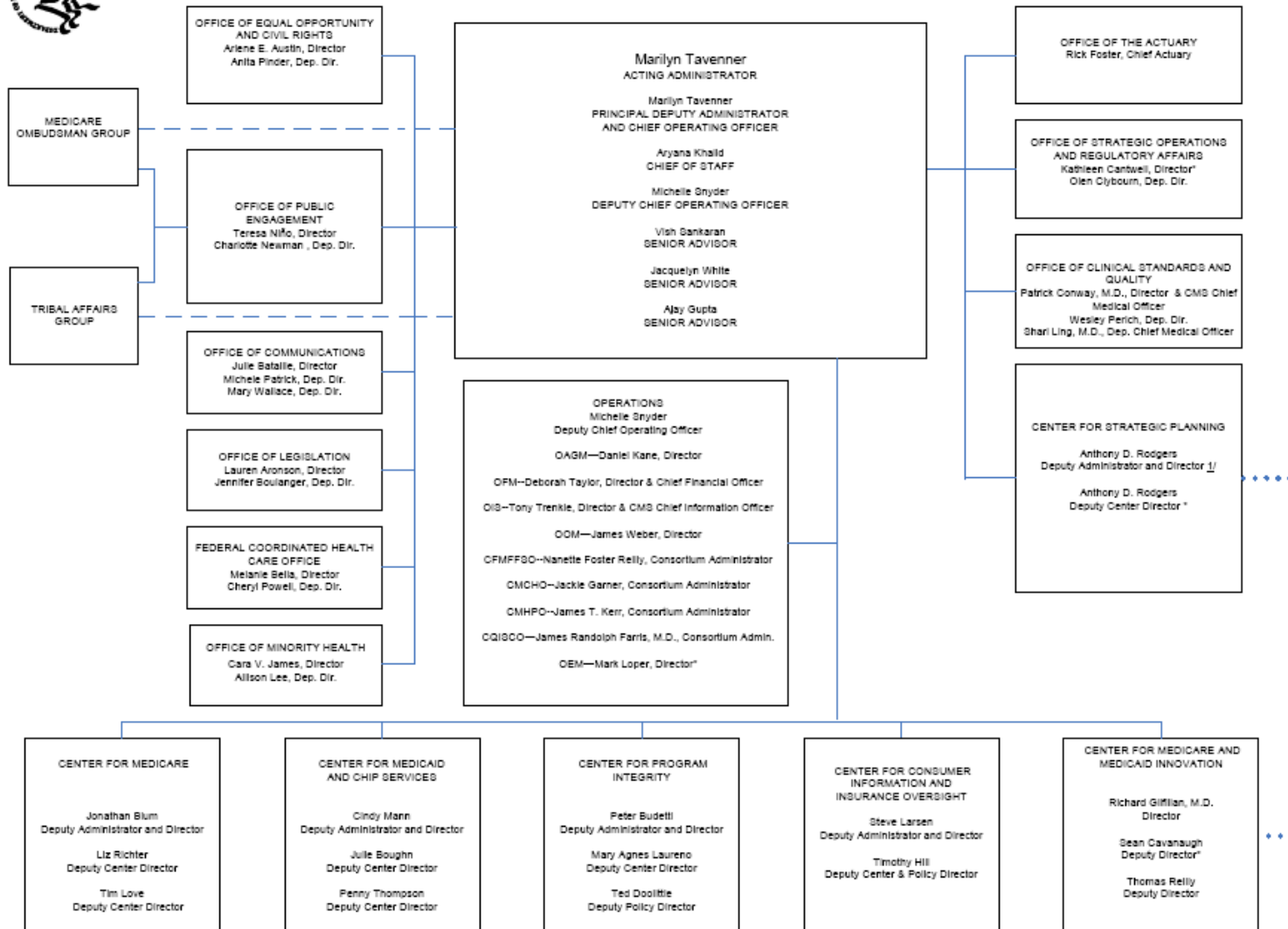
In sum, an Indian Tribe that has elected to directly operate its health care program can simultaneously serve in several capacities: as a sovereign government; as beneficiary of IHS-funded health care; as a direct provider of health care (including the right of recovery from third party payers); as administrator of a health program with responsibilities for advising its patients about eligibility for Medicare, Medicaid, and CHIP; and as a sponsor of a health insurance plan for its employees (and the payor under such a plan if it is a self-insured plan). CMS must take these multiple roles into account and fashion special policies to effectively implement Medicare, Medicaid, and CHIP in Indian communities in ways that assure full access by Indian beneficiaries and IHS/tribal providers.

APPENDIX C: CMS ORGANIZATION CHART



DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED LEADERSHIP
As of June 18, 2012
* Acting

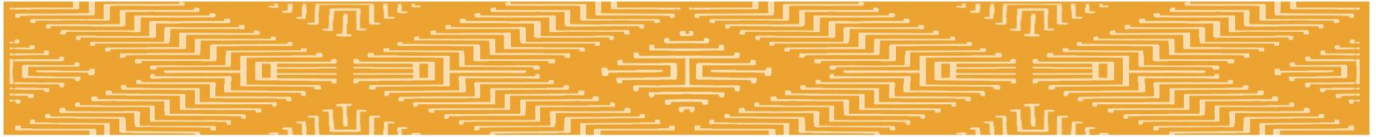


1/ Deputy Administrator and Director oversees the State Innovations Group

Appendix D: Common Terms & Acronyms

Agencies referenced are in CMS unless otherwise indicated*

ACA	Patient Protection and Affordable Care Act (P.L. 111-148)	I/T/U	Health care services operated by the IHS, Tribes and urban Indian clinics
AI/AN	American Indians and Alaska Natives	IHCIA	Indian Health Care Improvement Act (P.L. 94-437)
ACL	Administration for Community Living (in HHS)	IHS	Indian Health Service (federal agency in DHHS)
ARRA	American Recovery and Reinvestment Act of 2009 (P.L. 111-5)	LTSS	Long Term Services and Support
CCIIO	Center for Consumer Information and Insurance Oversight	MA	Medicare Advantage (managed care plan)
CHS	Contract Health Services, (IHS program to purchase services)	MAM	Medicaid Administrative Match
CHIP	Child Health Insurance Program	MOA	Memorandum of Agreement
CHIPRA	Children’s Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3)	NAC	Native American Contact in CMS Regional Offices
CMCS	Center for Medicaid and CHIP Service	NIHB	National Indian Health Board
CMM	Center for Medicare Management	OGC	Office of General Counsel
CMMI	Center for Medicare and Medicaid Innovation	Part A	Medicare inpatient coverage
CMS	Centers for Medicare & Medicaid Services	Part B	Medicare outpatient coverage
CMSO	Center for Medicaid and State Operations	Part C	Medicare managed care plans, also called Medicare Advantage
DHHS	Department of Health and Human Services	Part D	Medicare prescription drug benefit
FFE	Federally-facilitated Exchange	TAG	Tribal Affairs Group
FMAP	Federal Medical Assistance Percentage (for Medicaid)	TTAG	Tribal Technical Advisory Group
FQHC	Federally Qualified Health Centers	Title XVIII	Medicare, Social Security Act
HHS	Department of Health and Human Services*	Title XIX	Medicaid, Social Security Act
		Title XXI	Children’s Health Insurance Program , Social Security Act



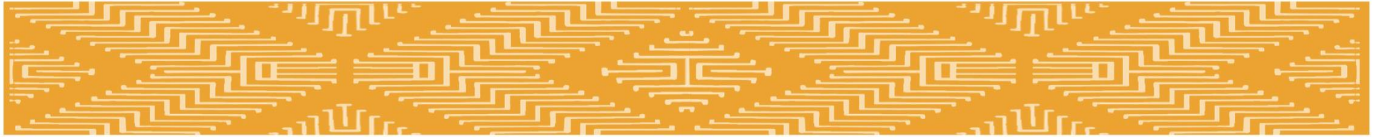
Acknowledgements

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This plan was developed over a period of six months, beginning in June 2012. The TTAG Strategic Plan Subcommittee met in-person and by conference call to develop new goals, objectives, and tasks. TTAG's subcommittees for Tribal Consultation, Long Term Care, Data, and Outreach & Education provided essential input related to their visions for future activities and outcomes. TTAG approved the plan for nationwide tribal comment and review in September 2012. The TTAG approved this final version of the plan at their face-to-face meeting in Washington, DC, on November 14, 2012.

This is the third AI/AN Strategic Plan developed by TTAG. Each plan has built on the work of the preceding plan, although much of the background information in previous plans has been dropped from this version to make it shorter. The first plan, for the period 2005-2010, was developed under the TTAG Strategic Plan Chairmanship of Margaret Terrance, Nashville Area Representative to TTAG, and was staffed by Mim Dixon, consultant. The second plan, for the period from 2010- 2015, was developed under the TTAG Strategic Plan Subcommittee, chaired by the Honorable W. Ron Allen, Chair of the Jamestown S'Klallam Tribe, and Tribal Self-Governance Advisory Committee representative to the TTAG. The staff for the second plan included Craig Carter, Stephanie Craig Rushing and Jim Roberts from NPAIHB, as well as Kitty Marx and Caitlin Wesaw who were then at NIHB.

TTAG would like to thank the many people in CMS who participated in interviews and provided their insights for the development of this plan. While we are keeping their names and comments confidential, we hope they will see the wisdom they shared reflected on these pages. Mim Dixon and Jim Roberts staffed this plan, with assistance from Lisa Griggs (NPAIHB), Tyra Baer (NIHB), and Liz Heintzman (NIHB).



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